Department of Health Care Policy and Financing

FY 2013-14 Strategic Operational Plan

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November 1, 2012

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Introduction

The Department of Health Care Policy and Financing is the federally designated Single State Agency to receive Medicaid (Title XIX) funding from the federal government for administration or supervision of the Medicaid program. As such, in order to receive federal financial participation, the Department is responsible for the provision of all health care services to persons who qualify as categorically needy under Title XIX of the Social Security Act. Most of the Department's programs are funded in part by the federal Centers for Medicare and Medicaid Services that provides roughly 50% of the Department's Medicaid budget and 65% of the funding for the Children's Basic Health Plan. The Department also provides health care policy leadership for the State's Executive Branch.

The Department oversees services and distributes administrative costs through interagency agreements with other departments. Because the Department is the Single State Agency designated to administer or supervise the administration of the Medicaid program, a number of statewide programs and services are financed through the Department's budget each fiscal year. Included in these programs and services are services for persons with developmental disabilities, mental health institutes, and nurse aide certifications.

The Department also receives Child Health Insurance Program (Title XXI) funding from the federal government for the Children's Basic Health Plan, marketed as Child Health Plan *Plus* or CHP+. CHP+ provides basic health insurance coverage for uninsured children and pregnant women of low-income families, and is a non-entitlement, non-Medicaid program that delivers coverage in accordance with the principles of private insurance. In addition to the Medicaid program and CHP+, the Department administers the following programs:

- The Old Age Pension State Medical Program provides limited medical care for individuals eligible for Old Age Pension grants.
- The Colorado Indigent Care Program distributes federal and state funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population.
- The School Health Services Program provides reimbursement to qualified school districts that provide health services to children enrolled in Medicaid.
- The Primary Care Fund, which is funded by taxes on tobacco products, provides an allocation of moneys to health care providers that provide basic health care services in an outpatient setting to residents of Colorado who are considered medically indigent.

Statutory Authority

The statutory authority for the Department can be found at Title 25.5 of the Colorado Revised Statutes.

25.5-4-104, C.R.S. Program of medical assistance - single state agency

(1) The state department, by rules, shall establish a program of medical assistance to provide necessary medical care for the categorically needy. The state department is hereby designated as the single state agency to administer such program in accordance with Title XIX and this article and articles 5 and 6 of this title. Such program shall not be required to furnish recipients under sixty five years of age the benefits that are provided to recipients sixty-five years of age and over under Title XVIII of the social security act; but said program shall otherwise be uniform to the extent required by Title XIX of the social security act.

25.5-8-104, C.R.S. Children's basic health plan - rules

The medical services board is authorized to adopt rules to implement the children's basic health plan to provide health insurance coverage to eligible persons on a statewide basis pursuant to the provisions of this article. Any rules adopted by the children's basic health plan policy board in accordance with the requirements of the "State Administrative Procedure Act", article 4 of title 24, C.R.S., shall be enforceable and shall be valid until amended or repealed by the medical services board.

25.5-3-104, C.R.S. Program for the medically indigent established - eligibility - rules

(1) A program for the medically indigent is hereby established, to commence July 1, 1983, which shall be administered by the state department, to provide payment to providers for the provision of medical services to eligible persons who are medically indigent. The state board may promulgate rules as are necessary for the implementation of this part 1 in accordance with article 4 of title 24, C.R.S.

SMART Government Act

The State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act (House Bill 10-1119) established a performance-based budgeting system for Colorado. This requires departments to create strategic plans outlining their goals and describe how those goals will be evaluated through performance measures. Section 2-7-201, et seq., C.R.S., requires departments to create 5-year strategic plans and to make those plans readily available to legislators and the public. Strategic plans must contain the following five components:

- The department's 5-year mission or vision
- Performance-based goals that correspond to the mission or vision
- Performance measures that correspond to the performance-based goals
- Strategies to meet the performance-based goals
- A performance evaluation providing a review of the department's outcomes as compared to the benchmarks stated in its performance measures

House Bill 11-1212 subsequently amended the SMART Government Act to encourage departments to consider "LEAN" principles when developing strategic plans. LEAN principles focus on increasing a department's efficiency and effectiveness by eliminating non value-added processes. The Department has integrated LEAN as a process improvement system into its 5-year Strategy Map, and established a LEAN Community to drive innovative changes in work processes, deployment of staff, and organizational policy.

Strategic Management Process

In January 2012, the Department initiated a new Strategic Management Process which operates year-round to formulate, implement, and evaluate strategy. Strategy formulation activities in calendar year 2012 centered on development of a 5-year Strategy Map (see page 8) as the cornerstone of the Department's FY 2013-14 Strategic Operational Plan. In developing its Strategy Map, the Department recorded over 500 "touchpoints" or interactions with managers and staff who contributed to the development of goals, strategies and performance measures. External and internal assessments were completed to prioritize and distill themes from a Department analysis of strengths, weaknesses, opportunities and threats (SWOT). Distilled themes were mapped to six "lenses" commonly used across private, public, and non-profit sectors to evaluate business success: Customers; Communication; Technology; People; Process; and Financing. These lenses, paired with Department themes, formed the foundation for the Department's six strategic goals listed below, which are designed to ensure ***customer-focused performance management*:**

- **Goal I** – Improve health outcomes, client experience and lower per capita costs1 **(Customer)**
- **Goal II** – Sustain effective internal and external relationships **(Communications)**
- **Goal III** – Provide exceptional service through technological innovation **(Technology)**
- **Goal IV** – Build and sustain a culture where we recruit and retain talented employees **(People)**
- **Goal V** – Enhance efficiency and effectiveness through process improvement **(Process)**
- **Goal VI** – Ensure sound stewardship of financial resources **(Financing)**

Strategic Operational Plan Organization

Due to the cross-functional nature of teamwork within the Department, its FY 2013-14 Strategic Operational Plan follows the ***goal-based organization*** of its Strategy Map. In addition, Goal I is the only goal with an external customer and programmatic focus. As a result, Goal I contains all of the Department's five-year performance measures. Goals II through VI are designed to make the Department more efficient, customer-focused, and operationally effective. Therefore, Goals II through VI contain one-year performance measures for current fiscal year operational plans.

Each goal and strategy listed on the Strategy Map is described in a subsequent logic model that links goals and strategies to specific objectives and performance measures. Monitoring of current year progress toward performance measures through an evaluation process ensures continual progress toward strategic goals. Details about strategy implementation and evaluation, with comparisons of actual results to benchmarks, are provided in the "Evaluation of Prior Year Performance" sections of the Strategic Operational Plan.

Department of Health Care Policy & Financing
5-Year Strategy Map

November 1, 2012

VISION

The Coloradans we serve have integrated health care and enjoy physical, mental and social well-being.

MISSION

Improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

GOALS

I. Improve health outcomes, client experience and lower per capita costs* (Customer)	II. Sustain effective internal and external relationships (Communications)	III. Provide exceptional service through technological innovation (Technology)	IV. Build and sustain a culture where we recruit and retain talented employees (People)	V. Enhance efficiency and effectiveness through process improvement (Process)	VI. Ensure sound stewardship of financial resources (Financing)
STRATEGIES					
A. Integrated Delivery System	A. Internal Communications	A. Health Information Technology (HIT)	A. Workforce Development	A. Strategic Management Process (SMP)	A. Cost Containment Extpertise
B. Benefit / Program Design	B. External Communications	B. Collaboration & File Sharing	B. Employee Engagement	B. LEAN Community	B. Fraud, Waste & Abuse Prevention
C. Payment Methodology	C. Government Affairs		C. Human Resources Transformation	C. Tri-Agency & Interagency Collaboration	C. Grants Management
D. Eligibility & Enrollment			D. Revitalization		
E. Client Experience & Engagement					

Logic Models & Implementation Plans

5-Year Programmatic Performance Measures

1-Year Operational Performance Measures

**Adapted from the Institute for Healthcare Improvement's Triple Aim.*

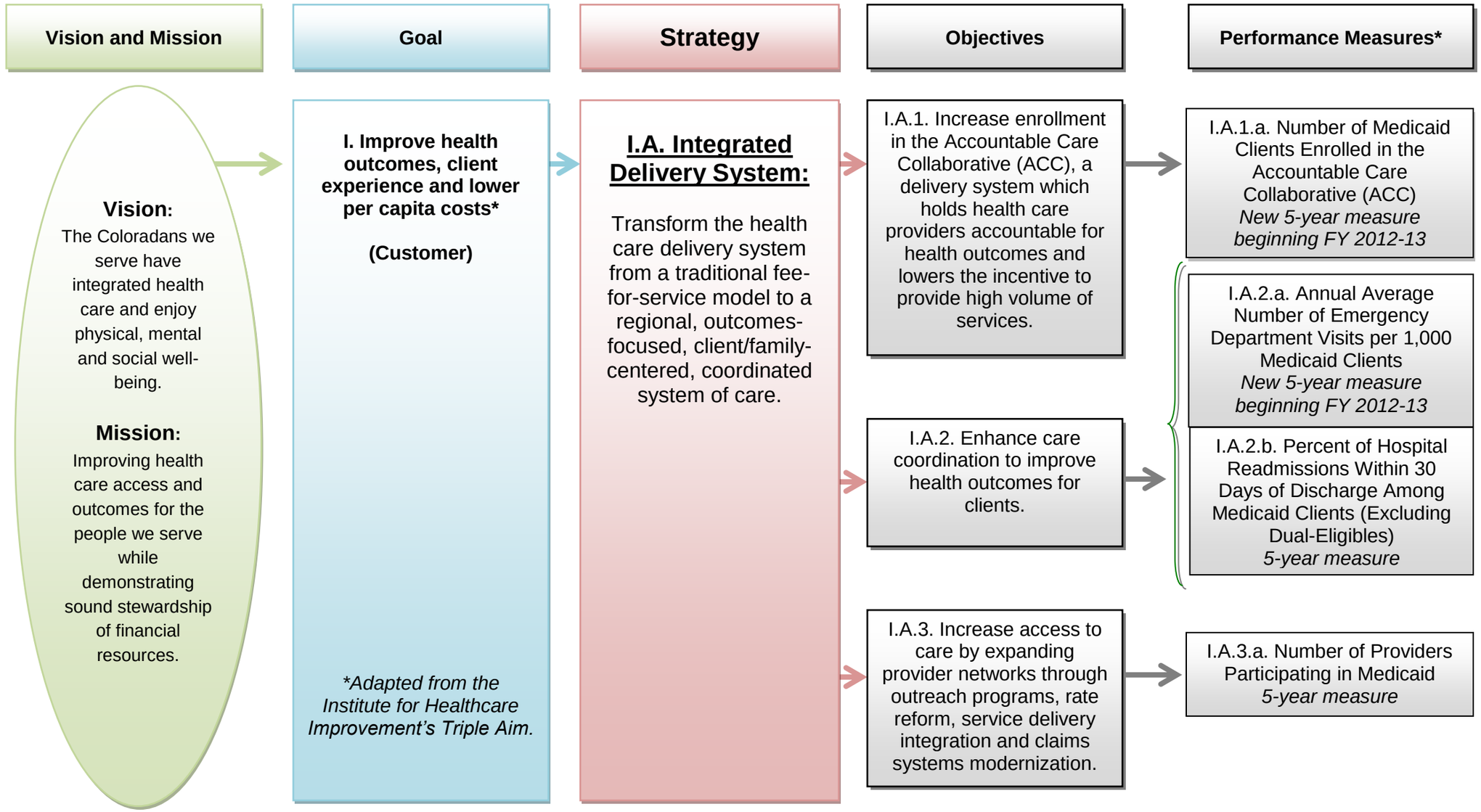
Goal I

I. Improve health outcomes, client experience and lower per capita costs*.

(Customer)

**Adapted from the Institute for Healthcare Improvement's Triple Aim.*

Strategy Map Logic Model - Goal I, Strategy A



** Performance Measure (PM) benchmarks vary by fiscal year – see Strategic Plan in FY 2013-14 Budget Request. The deadline is June 30 unless otherwise noted.*

Performance Measure I.A.1.a. Number of Medicaid Clients Enrolled in the Accountable Care Collaborative											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	N/A	124,449	200,000	TBD	300,000	TBD	400,000	TBD	500,000	TBD

Type: Output
Frequency: ☒Monthly ☐Quarterly ☐Semi-Annually ☐Annually ☐Other

Goal: I. Improve health outcomes, client experience and lower per capita costs* (Customer) **Adapted from the Institute for Healthcare Improvement's Triple Aim.*

Strategy I.A. Integrated Delivery System: *Transform the health care delivery system from a traditional fee-for-service model to a regional, outcomes-focused, client/family-centered, coordinated system of care.*

The Accountable Care Collaborative (ACC) is a Medicaid program to improve clients' health and reduce costs. Medicaid clients in the ACC will receive the regular Medicaid benefit package and will belong to a Regional Care Collaborative Organization (RCCO). Medicaid clients will also choose a Primary Care Medical Provider (PCMP). As a medical home, the PCMP will coordinate and manage a client's health needs across specialties and along the continuum of care, which improves health outcomes through a coordinated, client-centered system and controls costs by reducing avoidable, duplicative, variable, and inappropriate use of health care resources.

The ACC is a central part of Medicaid reform that changes the incentives and health care delivery processes for providers from one that rewards a high volume of services to one that holds providers accountable for health outcomes. The Department's November 1, 2012 Budget Request for FY 2013-14, R-6 "Additional FTE to Restore Functionality," supports this performance measure.

Evaluation of Prior Year Performance: Not applicable. New measure effective FY 2012-13.

Rationale for choosing the measure: Because the ACC has been established as the Department's framework for creating a focal point of care for clients, this new measure replaces former measures 3A, 3B and 5D (November 1, 2011 Budget Request), "Percent of adult Medicaid clients that have a medical home or focal point of care," "Percent of Medicaid children that have a medical home or focal point of care," and "Percent of the dual-eligible population that is enrolled in the Accountable Care Collaborative for a focal point of care," respectively.

Performance Measure I.A.2.a. Annual Average Number of Emergency Department Visits per 1,000 Medicaid Clients											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	N/A	Data available Dec 2012	N/A	TBD	744	TBD	744	TBD	744	TBD

Type: Outcome
Frequency: ☐Monthly ☐Quarterly ☐Semi-Annually ☒Annually ☐Other

Goal: I. Improve health outcomes, client experience and lower per capita costs* (Customer) **Adapted from the Institute for Healthcare Improvement's Triple Aim.*

Strategy I.A. Integrated Delivery System: *Transform the health care delivery system from a traditional fee-for-service model to a regional, outcomes-focused, client/family-centered, coordinated system of care.*

The Department's strategy for achieving the national Medicaid Health Maintenance Organization average of 744 Emergency Department visits per 1,000 clients is multi-pronged and includes the following activities:

- Implement this measure as a Key Performance Indicator (KPI) for the Accountable Care Collaborative (ACC) organizations
- Place high Emergency Department utilizers into the Client Overutilization Program
- Evaluate results of Emergency Department visits reduction efforts in other states to determine what activity is the most effective
- Engage hospitals and other providers in high-utilizing areas of the state to work with the Department in addressing client needs using less costly mechanisms of meeting the needs
- Investigate the possibility of expanding use of urgent care centers
- Notify providers when their clients use the Emergency Department for clients in the ACC program

The Department's November 1, 2012 Budget Request for FY 2013-14, R-7 "Substance Use Disorder Benefit," R-8 "Medicaid Dental Benefit for Adults," R-9 "Dental ASO for Children," and R-11 "HB 12-1281 Departmental Differences Reconciliation," support this performance measure.

Evaluation of Prior Year Performance: Not applicable. New measure effective FY 2012-13.

Rationale for choosing the measure: This measure was chosen because unnecessary Emergency Department visits increase the cost of health care. National comparative data show that 75% of Medicaid programs have Emergency Department visit rates lower than Colorado, indicating a significant opportunity to reduce Emergency Department visits in Colorado.

Performance Measure I.A.2.b. Percent of Hospital Readmissions Within 30 Days of Discharge Among Medicaid Clients (Excluding Dual-Eligibles)											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual[1]	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	9.95%	9.55%	TBD	9.65%	TBD	9.36%	TBD	9.08%	TBD	8.80%	TBD

[1] *FY 2011-12 data not available until January 2013 (requires six months paid date run-out).*

Type: Outcome
Frequency: ☐Monthly ☐Quarterly ☐Semi-Annually ☒Annually ☐Other

Goal: I. Improve health outcomes, client experience and lower per capita costs* (Customer) **Adapted from the Institute for Healthcare Improvement's Triple Aim.*

Strategy I.A. Integrated Delivery System: *Transform the health care delivery system from a traditional fee-for-service model to a regional, outcomes-focused, client/family-centered, coordinated system of care.*

There were many activities initiated to affect the 30 day hospital readmission rate during FY 2011-12:

- The readmission rate is now a key performance indicator for each Regional Care Collaborative Organization.
- A policy to deny payment for any readmission that occurred within 48 hours of a discharge was implemented July 1, 2011.
- A questionnaire was sent to all hospitals about their current efforts to decrease 30-day hospital readmissions. The intent of this questionnaire was to increase awareness of the importance of decreasing readmissions.
- A work group of Department staff was initiated to focus on activities that could be done to lower readmissions.
- A collaborative effort between the Center for Improving Value in Health Care, Colorado Hospital Association, Colorado Regional Health Information Organization, and the Department began investigating the need for a statewide initiative focused on reducing readmissions.

The Department's November 1, 2012 Budget Request for FY 2013-14, R-8 "Medicaid Dental Benefit for Adults" and R-11 "HB 12-1281 Departmental Differences Reconciliation," support this performance measure.

Evaluation of Prior Year Performance: In FY 2010-11, the percent of hospital readmissions within 30 days of discharge among Medicaid clients (excluding dual-eligibles) was 9.95%. This represents a correction to the 9.4% hospital readmission rate originally reported in the Department's FY 2012-13 Budget Request. As a result, the benchmark for FY 2011-12 was adjusted to 9.55% to reflect the targeted four-tenths of one percentage point decrease from the actual rate in FY 2010-11. The actual rate is based on an analysis of claims data six months after the close of the reporting period to allow for the completion of provider billing cycles. When compared to a 16-state Medicaid average of 8.3%, Colorado's readmission rate is nearly 1.7% higher than the other states. The Department will be able to gauge the success of the strategies employed in FY 2011-12 in February 2013.

Rationale for choosing the measure: Studies have shown that readmissions to the hospital within 30 days of a previous hospitalization is a hospitalization that can be avoided through actively managing a patient's transition from the hospital to the post-discharge caregiver (e.g. self, rehabilitation, home care, etc.). Reducing the readmission rate improves the care given to the patient and reduces the cost of care.

Performance Measure I.A.3.a. Number of Providers Participating in Medicaid											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	24,669	25,902	26,283	27,597	TBD	5%> FY 2012-13 Actual	TBD	5%> FY 2013-14 Actual	TBD	5%> FY 2014-15 Actual	TBD

Type: Output
Frequency: ☐Monthly ☐Quarterly ☒Semi-Annually ☐Annually ☐Other

Goal: I. Improve health outcomes, client experience and lower per capita costs* (Customer) **Adapted from the Institute for Healthcare Improvement's Triple Aim.*

Strategy I.A. Integrated Delivery System: *Transform the health care delivery system from a traditional fee-for-service model to a regional, outcomes-focused, client/family-centered, coordinated system of care.*

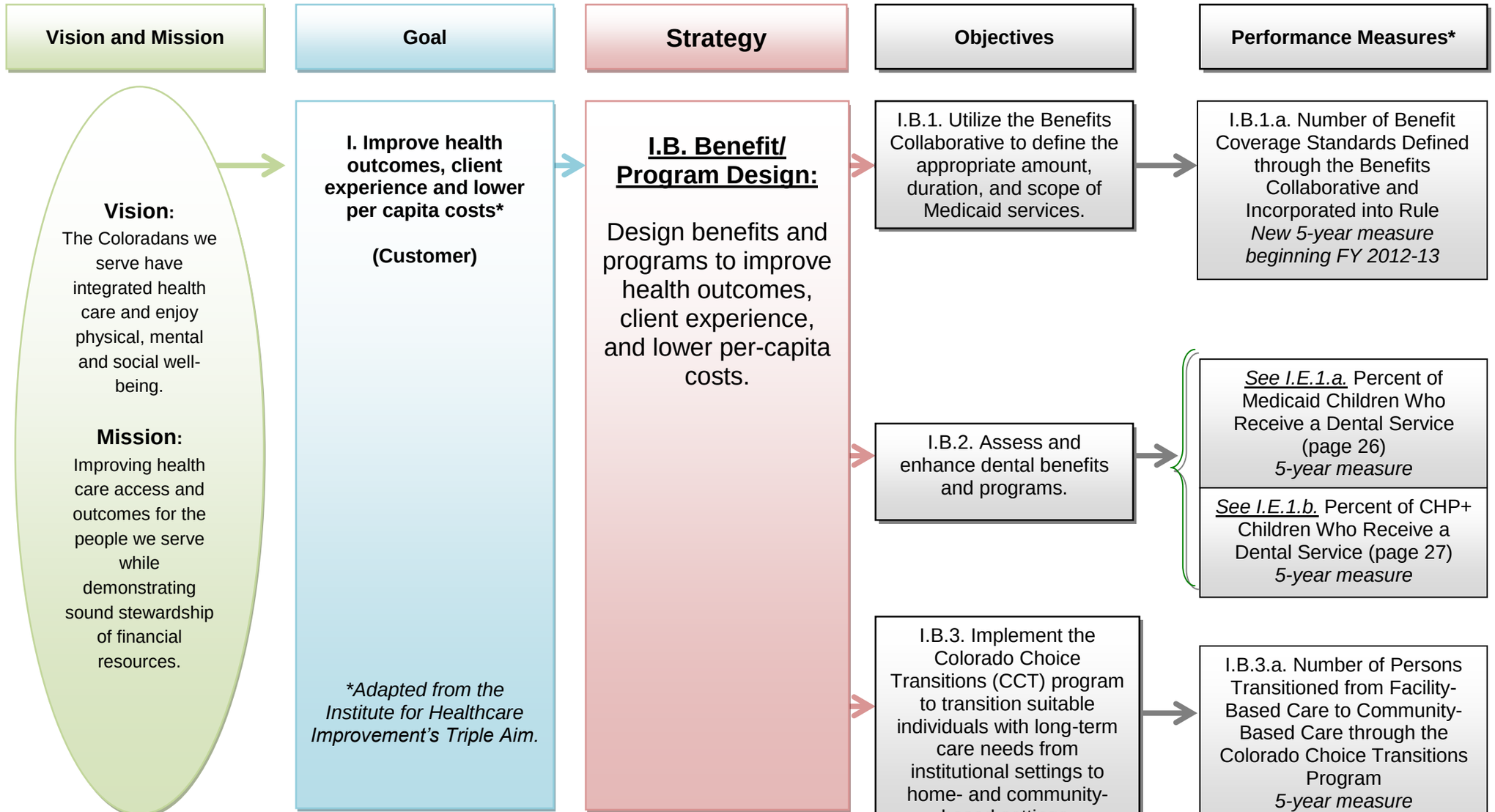
In FY 2011-12, the Department implemented provisions of the Health Resources and Services Administration-State Health Access Program (HRSA-SHAP) grant to create a Provider Relations team, consisting of two full-time staff, for the purpose of retaining existing Medicaid providers, assisting prospective providers in the enrollment process, and initiating a provider-recruitment strategy. In coming years, the Department's Regional Care Collaborative Organizations will encourage providers to join the Accountable Care Collaborative and become a Medicaid provider. The Clinical Services Office will also network with providers and provider organizations to recruit new providers.

The Department's November 1, 2012 Budget Request for FY 2013-14, R-6 "Additional FTE to Restore Functionality," R-8 "Medicaid Dental Benefit for Adults," R-9 "Dental ASO for Children," R-11 "HB 12-1281 Departmental Differences Reconciliation," and R-13 "1.5% Provider Rate Increase," support this performance measure.

Evaluation of Prior Year Performance: By the end of FY 2010-11, there were 24,669 Medicaid providers in Colorado. This represents a correction to the number of FY 2010-11 providers originally reported (27,336) in the Department's FY 2012-13 Budget Request. The corrected number reflects "active" providers with at least one claim per calendar year. As a result, the benchmark for FY 2011-12 has been adjusted to reflect a 5% increase over the FY 2010-11 actual number. The Department exceeded the corrected FY 2011-12 benchmark with a total of 26,283 Medicaid providers. This represents a 6.5% increase over the 24,669 Medicaid providers in FY 2010-11.

Rationale for choosing the measure: Program eligibility expansion directed by HB 09-1293 necessitates additional providers to meet the demand of newly enrolled participants. National health care reform legislation relies on further Medicaid eligibility expansion by 2014. The Department's efforts to increase provider enrollment has been calculated to keep pace with the increased program participation.

Strategy Map Logic Model - Goal I, Strategy B



** Performance Measure (PM) benchmarks vary by fiscal year – see Strategic Plan in FY 2013-14 Budget Request. The deadline is June 30 unless otherwise noted.*

Performance Measure I.B.1.a. Number of Benefit Coverage Standards Defined through the Benefits Collaborative and Incorporated into Rule											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	N/A	N/A	7	TBD	10	TBD	10	TBD	10	TBD

Type: Output
Frequency: ☐Monthly ☒Quarterly ☐Semi-Annually ☐Annually ☐Other

Goal: I. Improve health outcomes, client experience and lower per capita costs* (Customer) **Adapted from the Institute for Healthcare Improvement's Triple Aim.*

Strategy I.B. Benefit/ Program Design: *Design benefits and programs to improve health outcomes, client experience, and lower per-capita costs.*

The Benefits Collaborative is a stakeholder driven process for ensuring that benefit coverage standards are based on the best available clinical evidence; outline the appropriate amount, duration, and scope of Medicaid services and set reasonable limits upon those services; and promote the health and functioning of Medicaid clients. By using the Benefits Collaborative to define benefit coverage standards and incorporate them into rule, the Department can ensure appropriate utilization, statewide equity, and consistency in the delivery of services. Clearly defined standards help ensure proper payment for benefits, improve guidance for service providers, and ensure responsible allocation of taxpayer dollars. In addition, savings may be realized as a result of more appropriate utilization of benefits. Administrative overhead may be reduced by decreasing the number of appeals and improving the defensibility of Department decisions due to increased clarity of coverage.

The Department's November 1, 2012 Budget Request for FY 2013-14, R-5 "Medicaid Management Information System Reprocurement" and R-6 "Additional FTE to Restore Functionality," support this performance measure.

Evaluation of Prior Year Performance: Not applicable. New measure effective FY 2012-13.

Rationale for choosing the measure: Increasing the number of benefit coverage standards defined through the Benefits Collaborative will improve the clarity of available benefits, simplify access, and ensure providers are paid for appropriate services.

Performance Measure I.B.3.a. Number of Persons Transitioned from Facility-Based Care to Community-Based Care through the Colorado Choice Transitions Program											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	N/A	N/A	100	TBD	100	TBD	100	TBD	100	TBD

Type: Output
Frequency: ☐Monthly ☐Quarterly ☐Semi-Annually ☒Annually ☐Other

Goal: I. Improve health outcomes, client experience and lower per capita costs* (Customer) **Adapted from the Institute for Healthcare Improvement's Triple Aim.*

Strategy I.B. Benefit/ Program Design: *Design benefits and programs to improve health outcomes, client experience, and lower per-capita costs.*

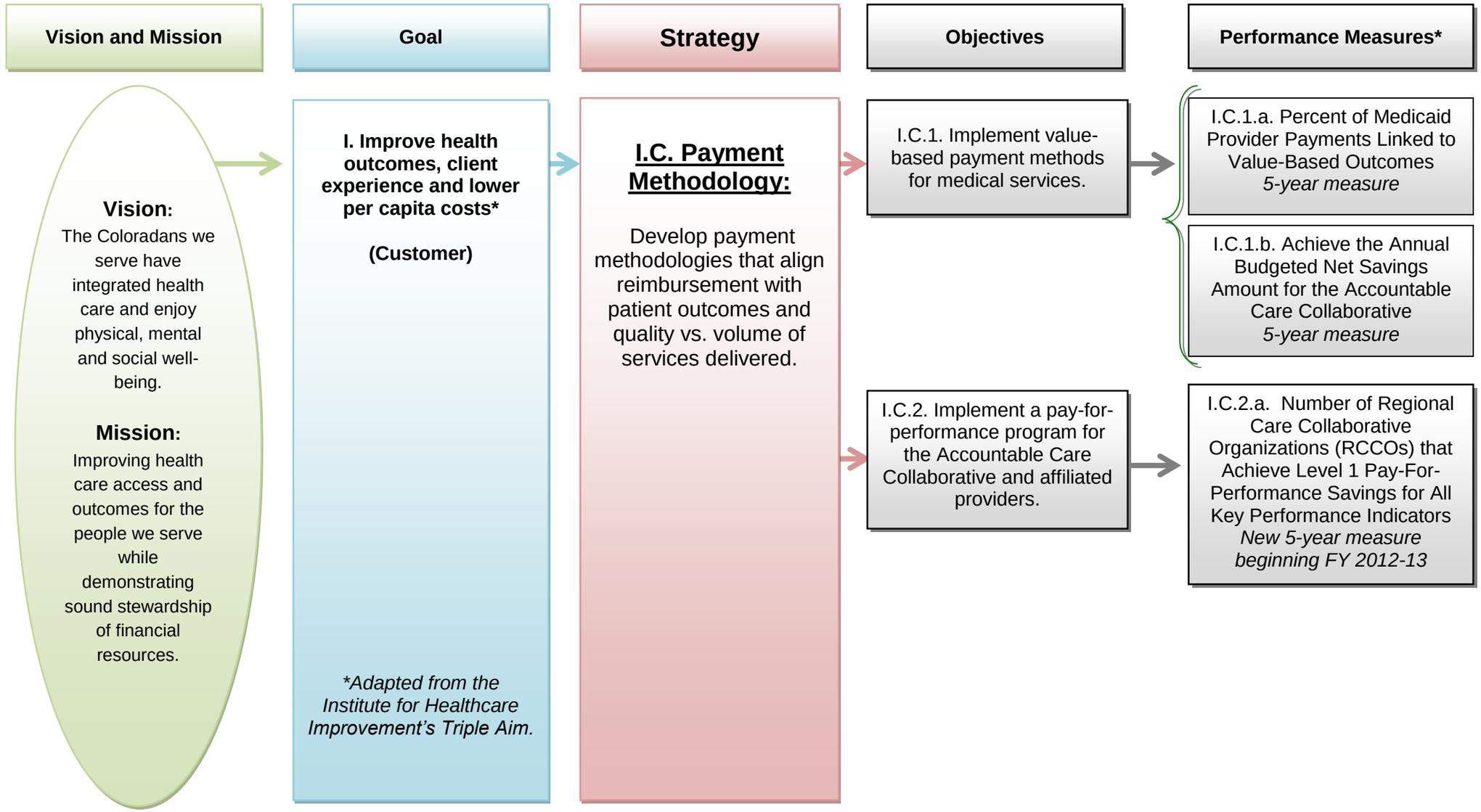
The Department is using the Colorado Choice Transitions (CCT) program to achieve this benchmark. The CCT program is made by possible by a $22 million, five-year federal grant. The grant is designed to build the home- and community-based services (HCBS) infrastructure to assist residents of long-term care facilities who are appropriate for community-based care to transition and receive services in a home of their choice. Clients will receive additional services through CCT for one year in addition to traditional community-based services already available in the Medicaid HCBS programs. The CCT-specific services include case management, independent-living skills trainings, community-transition services, and other services to assist clients with establishing a residence in the community and to facilitate a greater sense of independence following discharge. To be eligible for the program, a client must currently reside in a nursing home or an Intermediate Care Facility for Persons with Intellectual and/or Developmental Disabilities and be Medicaid eligible.

The Department's November 1, 2012 Budget Request for FY 2013-14, R-6 "Additional FTE to Restore Functionality," supports this performance measure.

Evaluation of Prior Year Performance: Not applicable. New measure effective FY 2012-13.

Rationale for choosing the measure: The Department chose this measure because the number of transitions that occur per year is a direct indicator of how successful the State is transitioning clients from facility-based care. This number can also be used to extrapolate the savings as a result of serving more clients in the community by using the average cost per client of services as a basis of comparison between facility-based services and community-based services.

Strategy Map Logic Model - Goal I, Strategy C



** Performance Measure (PM) benchmarks vary by fiscal year – see Strategic Plan in FY 2013-14 Budget Request. The deadline is June 30 unless otherwise noted.*

Performance Measure I.C.1.a. Percent of Medicaid Provider Payments Linked to Value-Based Outcomes											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	N/A	N/A	1.25%	TBD	2%	TBD	3.25%	TBD	5%	TBD

I.C.2. Implement a pay-for-performance program for the Accountable Care Collaborative and affiliated providers.

Type: Outcome
Frequency: ☐Monthly ☐Quarterly ☐Semi-Annually ☒Annually ☐Other

Goal: I. Improve health outcomes, client experience and lower per capita costs* (Customer) **Adapted from the Institute for Healthcare Improvement's Triple Aim.*

Strategy I.C. Payment Methodology: *Develop payment methodologies that align reimbursement with patient outcomes and quality vs. volume of services delivered.*

The Department has implemented, and continues to implement initiatives that reestablish the connection between value-based outcomes and provider reimbursement. In creating financial incentives for providers to take on greater roles in maintaining and improving the health of clients and their subsequent medical service utilization, the Department is taking the first steps towards transitioning away from a pay-for-volume system to a pay-for-value system. To date, Department initiatives include making incentive payments to providers for reduced emergency department utilization, reduced inpatient hospital utilization, reduced high-cost imaging usage, nursing facility pay-for-performance, and quality-based outcomes for hospitals.

The Department's November 1, 2012 Budget Request for FY 2013-14, R-5 "Medicaid Management Information System Reprocurement" R-6 "Additional FTE to Restore Functionality," and R-11 "HB 12-1281 Departmental Differences Reconciliation," support this performance measure.

Evaluation of Prior Year Performance: Not applicable. New measure effective FY 2012-13.

Rationale for choosing the measure: One of the most important Department endeavors of the last several years has been establishment of the Accountable Care Collaborative (ACC). The structure of the ACC facilitates payment reform while strengthening the continuum of care. In addition, implementation of House Bill 12-1281 "Medicaid Payment Reform Pilot Program" will improve on the ACC model by authorizing the Department to develop a new payment methodology to move further away from fee-for-service to a comprehensive method that pays for quality care and improving care transitions. This performance measure will help the Department evaluate the connection between value-based payment methods, client health outcomes and lower per capita costs.

Performance Measure I.C.1.b. Achieve the Annual Budgeted Net Savings Amount for the Accountable Care Collaborative *Formerly "Percent of Medical Services Premiums expenditures for clients enrolled in the ACC compared to clients not enrolled in the ACC"*											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark[1]	Actual	Benchmark[1]	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	N/A	($2,708,711)	($5,929,725)	TBD	($6,459,932)	TBD	TBD	TBD	TBD	TBD

[1] *Annual budgeted net savings benchmarks fluctuate by caseload mix – final estimates are provided each February. Preliminary benchmarks for FY 2012-13 and FY 2013-14 are from the Department's November 1, FY 2013-14 Budget Request, page R-1.91*

Type: Outcome
Frequency: ☐Monthly ☐Quarterly ☐Semi-Annually ☒Annually ☐Other

Goal: I. Improve health outcomes, client experience and lower per capita costs* (Customer) **Adapted from the Institute for Healthcare Improvement's Triple Aim.*

Strategy I.C. Payment Methodology: *Develop payment methodologies that align reimbursement with patient outcomes and quality vs. volume of services delivered.*

Transitioning from a volume-based payment structure to a system that pays for value requires physician and health plan accountability and coordination. The goal of a value-based payment system is to support doctors with payments that incentivize them to provide optimal care for their patients in the most efficient setting, while avoiding duplicative services. A model that successfully implements these initiatives should result in lower medical costs and improved health outcomes. The Department supports the Accountable Care Collaborative (ACC) program as a first step toward this aim. A November 1, 2012 impact analysis of the ACC program shows reduced utilization rates for emergency room visits, hospital readmissions, and high-cost imaging services; lower rates of chronic health conditions such as asthma and diabetes; and reduced total cost of care for clients enrolled in the ACC Program compared to clients not enrolled in the program. Beginning in FY 2012-13 a portion of payments made to providers and care coordination entities participating in the program is earned by achieving specific utilization targets as well as reducing total cost of care. Consequently, the program will demonstrate not only the impact of better care coordination, but also the effect of implementing payment methodologies that purchase value. Performance measure I.C.1.b. will enable the Department to evaluate the impact of the ACC program on reducing expenditures for medical services while accounting for program investment.

The Department's November 1, 2012 Budget Request for FY 2013-14, R-6 "Additional FTE to Restore Functionality" and R-11 "HB 12-1281 Departmental Differences Reconciliation," support this performance measure.

Evaluation of Prior Year Performance: Not applicable. New measure effective FY 2012-13.

Rationale for choosing the measure: The ACC Program focuses on purchasing value through care coordination and performance based payment; measuring program savings provides insight into the efficacy of the Department's value-based purchasing efforts with regard to patient outcomes and quality.

Performance Measure I.C.2.a. Number of Regional Care Collaborative Organizations (RCCOs) that Achieve Level 1 Pay-For-Performance Savings for All Key Performance Indicators											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark[1]	Actual	Benchmark[1]	Actual	Benchmark[1]	Actual
N/A	N/A	N/A	N/A	5	TBD	TBD	TBD	TBD	TBD	TBD	TBD

[1] *To reflect evolving Department goals while improving data sources for the ACC Program, KPIs will be revised each fiscal year until the ACC program and its methodologies for data analysis become firmly established.*

Type: Outcome
Frequency: ☐Monthly ☐Quarterly ☐Semi-Annually ☒Annually ☐Other

Goal: I. Improve health outcomes, client experience and lower per capita costs* (Customer) **Adapted from the Institute for Healthcare Improvement's Triple Aim.*

Strategy I.C. Payment Methodology: *Develop payment methodologies that align reimbursement with patient outcomes and quality vs. volume of services delivered.*

In July 2012, the Department began withholding one dollar of the per-member per-month (PMPM) capitation being paid to the Accountable Care Collaborative (ACC) Regional Care Collaborative Organizations (RCCOs) and Primary Care Medical Providers (PCMPs) for a pay-for-performance incentive plan. The RCCOs and PCMPs may recover this dollar if certain thresholds are achieved as measured by the three Key Performance Indicators (KPIs) below:

1. Hospital All-Cause Thirty (30) Day Readmissions;
2. Emergency Room (ER) Visits; and
3. High Cost Imaging Services.

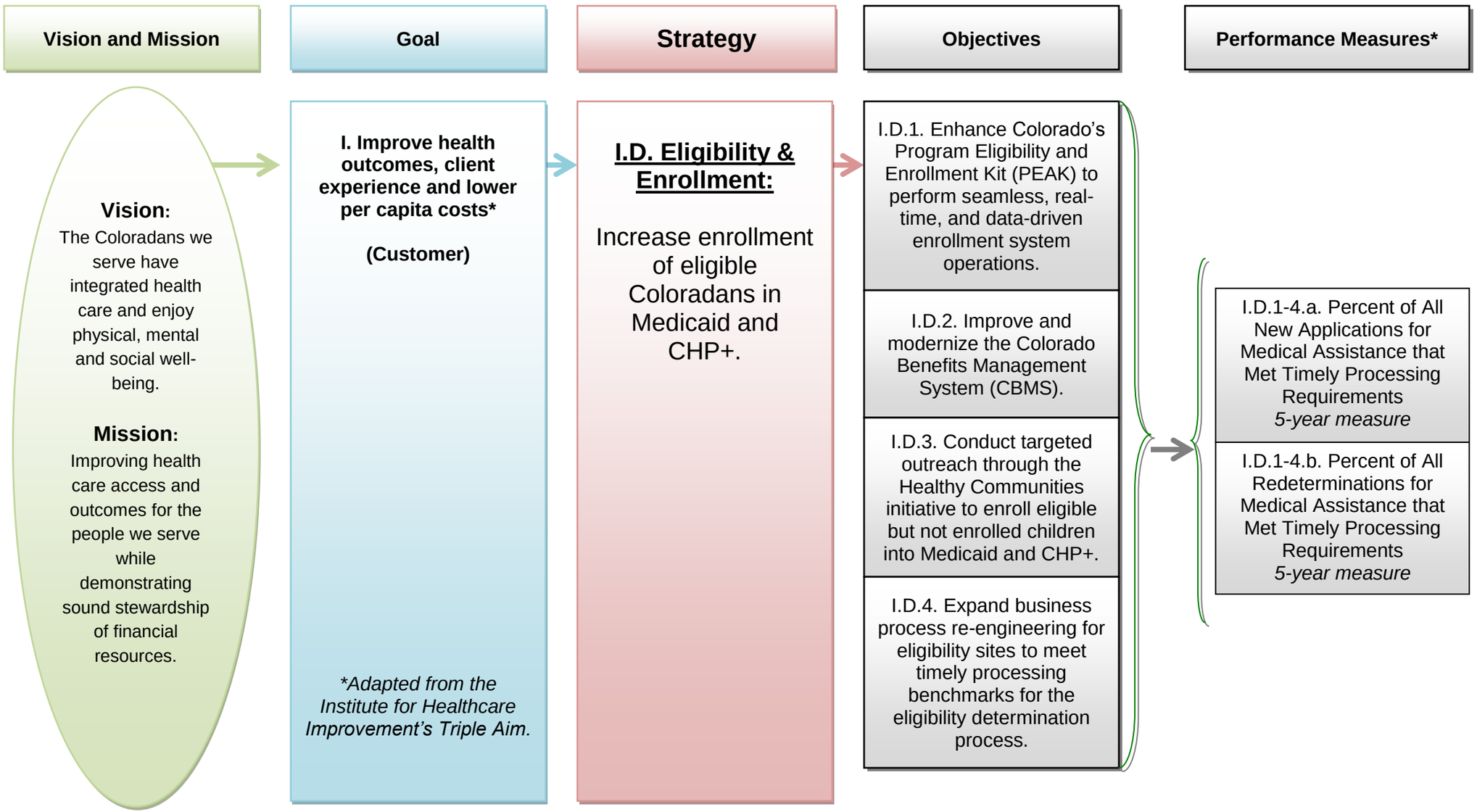
Each KPI calculation is based on service utilization by the population enrolled in the ACC. Performance is measured as a percentage point improvement from the base period. To account for regional variation, each RCCO is compared to the performance of its region during the base year. Improvement is measured by subtracting the program year-to-date performance from the regionally adjusted base year performance. There are two levels of performance achievement: Level 1 savings indicate a 1-5% reduction in a particular KPI from the base period; and Level 2 savings indicate a greater than 5% reduction in a particular KPI relative to the base period.

A reduction greater than 5% for each KPI results in a PMPM incentive payment of $0.33, for a total incentive payment of one dollar if all three KPIs meet the Level 1 savings. Similarly, a reduction between 1-5% for each KPI results in a PMPM incentive payment equal to 66% of $0.33, or $0.22. Incentive payments for each member are calculated based on performance of the region in which the member lives. For more information, see the Department's November 1, 2012 Budget Request for FY 2013-14: Department Description on pages B-24 and B-25 and R-11 "HB 12-1281 Departmental Differences Reconciliation."

Evaluation of Prior Year Performance: Not applicable. New measure effective FY 2012-13.

Rationale for choosing the measure: By measuring the number of RCCOs that Achieve Level 1 Pay-For-Performance Savings, the Department can assess the effectiveness of its ACC Pay-For-Performance Program. To reflect evolving Department goals while improving data sources for the ACC Program, KPIs will be revised each fiscal year until the ACC program and its methodologies for data analysis become firmly established.

Strategy Map Logic Model - Goal I, Strategy D



** Performance Measure (PM) benchmarks vary by fiscal year – see Strategic Plan in FY 2013-14 Budget Request. The deadline is June 30 unless otherwise noted.*

Performance Measure I.D.1-4.a. Percent of All New Applications for Medical Assistance that Meet Timely Processing Requirements											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	N/A	87%	95%	TBD	95%	TBD	95%	TBD	95%	TBD

Type: Outcome
Frequency: ☐Monthly ☐Quarterly ☐Semi-Annually ☒Annually ☐ Other

Performance Measure I.D.1-4.b. Percent of All Redeterminations for Medical Assistance that Meet Timely Processing Requirements											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	N/A	86%	95%	TBD	95%	TBD	95%	TBD	95%	TBD

Type: Outcome
Frequency: ☐Monthly ☐Quarterly ☐Semi-Annually ☒Annually ☐ Other

Goal: I. Improve health outcomes, client experience and lower per capita costs* (Customer) **Adapted from the Institute for Healthcare Improvement's Triple Aim.*

Strategy I.D. Eligibility & Enrollment: *Increase enrollment of eligible Coloradans in Medicaid and CHP+.*

The Department has initiated a multi-pronged approach to achieve both of the above benchmarks in FY 2012-13. The multi-pronged approach included:

- Improvements to the Colorado Benefits Management System (CBMS), eligibility system processing speed through CITRIX upgrades, and moving the entire system to a web-based format;
- heightened awareness of the timeliness, processing standards, and corrective action plan benchmarks through communication and outreach. This was conducted through individual eligibility site visits, Director's letters, regular community meetings and trainings. Additionally, eligibility sites were provided with monthly reports outlining processing times;
- reviews of conflicting policies and clarification offered to eligibility sites;
- research and identification of the top reasons applications are pending and communicating this to eligibility sites that work the cases, as well as working with the CBMS vendor if the pending applications are related to system issues;
- focused technical assistance to eligibility sites that are not meeting percentage goals through weekly progress reports on the timeliness percentages so the Department can contact each site that is below the processing requirement to offer technical assistance and support;
- the development of additional reports on pending cases or cases identified within exceptions reports that need to be prioritized and worked by individual eligibility sites to assist in their workload management;

- providing, through grant funding, additional processing assistance through the Integrated Document Solutions as the Overflow Unit to process family Medicaid/CHP+ applications and redeterminations for eligibility sites that requested assistance. The Department also funded staffing hours for county eligibility staff to perform overtime to assist with processing time frames;
- the introduction of business process improvements strategies through the Colorado Eligibility Process Improvement Collaborative (CEPIC). County departments implemented new processing strategies that encompassed business process improvements, staggered work hours to alleviate some of the system activity during peak hours, and overtime for eligibility technicians to decrease the backlog. Further, the Department trained eligibility sites on business process improvements and LEAN to provide ongoing support to those sites as they initiated changes;
- research and data fixes to clean up administratively incorrect data or issues with interfaces that adversely impacted the processing time performance statistics; and
- implementing the web-based PEAK online application, which was reported to have assisted with decreasing the eligibility sites' average processing of cases due to the upload process.

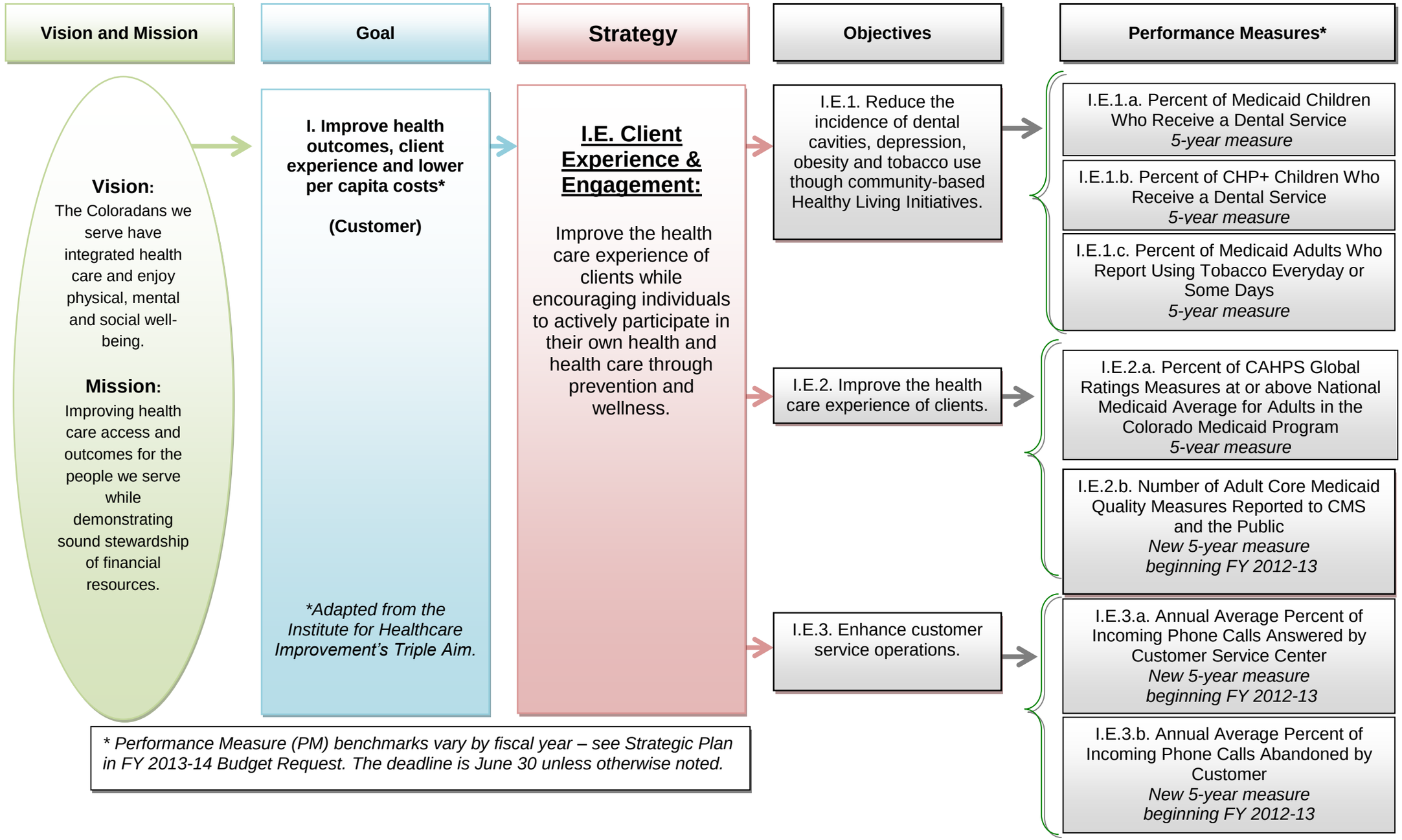
Several program automations and system changes were implemented to decrease workload and increase efficiency. These program changes included:

- administrative renewal, which eliminates the need for worker intervention on many redeterminations and aligns redetermination dates across multiple programs in order to eliminate multiple redetermination dates on one case;
- automation of the ex-parte process;
- implementing the Income and Eligibility Verification System (IEVS) interface that verifies client income for clients through the Colorado Department of Labor and Employment. This initiative allows clients to self-declare their verifiable work income for all Medicaid programs, which decreases paperwork delays in processing complete applications and redeterminations;
- implementing the Social Security Administration (SSA) interface that verifies citizenship and identity for U.S. citizens. This initiative allows clients to self-declare their U.S. citizenship status for all Medicaid programs, which decreases paperwork delays in processing complete applications and redeterminations; and
- completing a case assignment system fix which assigned Family Medicaid/CHP+ applications to the user or user's office/county taking the application; and added an authorization trigger to prevent these applications from remaining in a pending status. This change also created two new detail reports to assist the eligibility sites with their new applications and redeterminations.

Evaluation of Prior Year Performance:
During FY 2011-12, the Department worked collaboratively with eligibility sites to improve efficiencies for enrolling and processing client applications. As a result of these efforts, 87% of all new applications and 86% of all redeterminations met timely processing requirements for medical assistance. Timeliness of processing new applications increased 2% over the Department's internal benchmark of 85% by June 30, 2012; and timeliness of processing redeterminations increased 21% over the Department's internal benchmark of 65% by June 30, 2012.

Rationale for choosing the measures:
Timely processing is important to Department customers, and plays a vital role in the successful enrollment of eligible individuals in Medicaid and CHP+.

Strategy Map Logic Model - Goal I, Strategy E



** Performance Measure (PM) benchmarks vary by fiscal year – see Strategic Plan in FY 2013-14 Budget Request. The deadline is June 30 unless otherwise noted.*

Performance Measure I.E.1.a. Percent of Medicaid Children Who Receive a Dental Service											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	49%	51%	52%	53%	TBD	55%	TBD	57%	TBD	59%	TBD

Type: Outcome
Frequency: ☐Monthly ☒Quarterly ☐Semi-Annually ☐Annually ☐Other

Goal: I. Improve health outcomes, client experience and lower per capita costs* (Customer) **Adapted from the Institute for Healthcare Improvement's Triple Aim.*

Strategy I.E. Client Experience & Engagement: *Improve the health care experience of clients while encouraging individuals to actively participate in their own health and health care through prevention and wellness.*

To increase the number of Medicaid children who have access to dental care and receive dental services, the Department is developing an Oral Health Care Action Plan with guidance from the Centers for Medicare and Medicaid Services and the Colorado Oral Health stakeholder community. The Action Plan will implement four Medicaid oral health care goals, including one to increase the number of Medicaid children receiving oral health care services by 10 percentage points in a four-year period. The Department expects to complete and implement parts the Action Plan starting January l, 2013. The Department has also agreed to an external, comprehensive dental benefit review funded by Caring for Colorado. The Department anticipates the reviewer will look at the benefit in its entirety to determine best practices and/or benefit design to maximize Departmental and national strategic goals of increasing access to evidenced-based, preventive services for clients. The Department's November 1, 2012 Budget Request for FY 2013-14, R-9 "Dental ASO for Children," supports this performance measure.

Evaluation of Prior Year Performance: In federal fiscal year 2010-11, approximately 52% of Medicaid children received a dental service. These estimates are calculated from data provided to the federal Centers for Medicare and Medicaid Services (CMS) and represent the number of children who have been continuously enrolled in Medicaid for at least 90 days and received any dental service between October 1, 2010, and September 30, 2011.

The Department has observed a steady increase of approximately 2.5% per year over the past four years in Medicaid children receiving a dental service. The Department has observed a commensurate increase in dental provider enrollment and outreach, which increased needed access for clients. In addition, medical providers have been educated to screen and refer children for necessary dental services. Dental staff at the Department will continue to work on internal and external statewide initiatives for continued outreach to both dental providers and clients.

Due to the one-year lag in data available from the federal report the Department uses to evaluate this performance measure ("EPSDT CMS 416 report"), the Department uses data from the most recent year available as a proxy for the number of children receiving dental services in the measurement year. This methodology may, however, understate the actual result, as older data cannot account for progress made during the actual measurement year.

Rationale for choosing the measure: Studies show children who receive dental services are healthier, both physically and mentally.

Performance Measure I.E.1.b. Percent of CHP+ Children Who Receive a Dental Service											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	44%	46%	41%	45%	TBD	47%	TBD	49%	TBD	51%	TBD

Type: Outcome
Frequency: ☐Monthly ☐Quarterly ☐Semi-Annually ☒Annually ☐Other

Goal: I. Improve health outcomes, client experience and lower per capita costs* (Customer) **Adapted from the Institute for Healthcare Improvement's Triple Aim.*

Strategy I.E. Client Experience & Engagement: *Improve the health care experience of clients while encouraging individuals to actively participate in their own health and health care through prevention and wellness.*

To increase the number of Children's Basic Health Plan (CHP+) children who have access to dental care and receive dental services, the Department is developing an Oral Health Care Action Plan in concert with the CHP+ Oral Health Care Contractor and with guidance from the Centers for Medicare and Medicaid Services (CMS) and the Colorado Oral Health stakeholder community. The Action Plan will implement four CHP+ oral health care goals, including one to increase the number of CHP+ children receiving oral health care services by 10 percentage points over a four-year period. The Department expects to complete and implement parts of the Action Plan beginning 2013. In addition, the Department spent the past year drafting a Request for Proposals (RFP) for a new CHP+ Oral Health Care Contract effective July 1, 2013. The goals, strategies, and tactics of the Action Plan are incorporated in this RFP.

Evaluation of Prior Year Performance: In federal fiscal year 2010-11, approximately 41% of CHP+ children received a dental service. These estimates are calculated from data provided by the CHP+ Oral Health contractor based on the federal Centers for Medicare and Medicaid Services (CMS) methodology for the Medicaid EPSDT CMS 416 report discussed above and represent the number of children who have been continuously enrolled in CHP+ for at least 90 days and received any dental service between October 1, 2010, and September 30, 2011.

While there was a decrease in CHP+ oral health care utilization from FY 2010-11 to FY 2011-12, the Department believes this is largely due to a change in the methodology used to calculate this measure. Through FY 2010-11, the methodology measured utilization relative to the average CHP+ annual caseload rather than the number of children continuously enrolled in CHP+ for at least 90 days. This change in methodology is consistent with a recent CMS requirement that state CHIP programs adopt the standardized Medicaid methodology for calculating oral health care benefit utilization.

Due to the one-year lag in the data used by the Department to evaluate this performance measure (consistent with the EPSDT CMS 416 report), the Department uses data from the most recent year available as a proxy for the number of children receiving dental services in the measurement year. This methodology may, however, understate the actual result, as older data cannot account for progress made during the actual measurement year.

Rationale for choosing the measure: Studies show children who receive dental services are healthier, both physically and mentally.

Performance Measure I.E.1.c. Percent of Medicaid Adults Who Report Using Tobacco Everyday or Some Days											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	N/A	27.5%	N/A	TBD	25%	TBD	23%	TBD	21%	TBD

Type: Outcome
Frequency: ☐Monthly ☐Quarterly ☐Semi-Annually ☒Annually ☐Other

Goal: I. Improve health outcomes, client experience and lower per capita costs* (Customer) **Adapted from the Institute for Healthcare Improvement's Triple Aim.*

Strategy I.E. Client Experience & Engagement: *Improve the health care experience of clients while encouraging individuals to actively participate in their own health and health care through prevention and wellness.*

The Medicaid program in Colorado now has a comprehensive tobacco cessation benefit, including coverage of all U.S. Food and Drug Administration approved tobacco cessation products and medications for two quit attempts per year, as well as referrals to the Colorado QuitLine for coaching and support.

- The Department released tool kits for providers, which give guidance on billing and reimbursement for addressing tobacco use in the primary care setting.
- The Department increased collaboration between its staff and the Colorado Department of Public Health and Environment regarding the QuitLine, which led to an expansion of outreach efforts to Medicaid clients encouraging them to call the QuitLine for support.
- The Centers for Medicare and Medicaid Services now allows for federal matching funds to reimburse the QuitLine for services provided to Medicaid clients.
- The Medicaid customer service line will soon link callers directly to the QuitLine if they respond to a prompt which says, "Call the QuitLine now for help if you want to quit smoking".
- Pregnant women are now eligible for individual tobacco cessation counseling throughout pregnancy and the postpartum period.

Evaluation of Prior Year Performance: Not applicable. New measure effective FY 2013-14.

Rationale for choosing the measure: Poor health outcomes associated with tobacco use are well documented, and smoking is linked to cardiovascular and lung disease. Data from the Behavioral Risk Factor Surveillance System (BRFSS) show that the prevalence of tobacco use in the Medicaid population is higher than the statewide average. According to BRFSS, 28% of adults in the Medicaid program report that they regularly use tobacco, compared to a statewide average of 16%. This data is confirmed by the data reported in the table above from the Client Annual Health Plan Survey (CAHPS), which shows that 27.5% of adults report using tobacco regularly. This is one of the significant health disparities for the Medicaid population. As the Department tracks trends in the prevalence of tobacco use, it anticipates an impact from increased and committed efforts to educate Medicaid clients and provide them with the resources necessary to quit successfully. Smoking cessation will improve the health of the Medicaid population.

Performance Measure I.E.2.a. Percent of CAHPS Global Ratings Measures at or above National Medicaid Average for Adults in the Colorado Medicaid Program											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
100%	75%	100%	100%	100%	TBD	100%	TBD	100%	TBD	100%	TBD

Type: Outcome
Frequency: ☐Monthly ☐Quarterly ☐Semi-Annually ☒Annually ☐Other

Goal: I. Improve health outcomes, client experience and lower per capita costs* (Customer) **Adapted from the Institute for Healthcare Improvement's Triple Aim.*

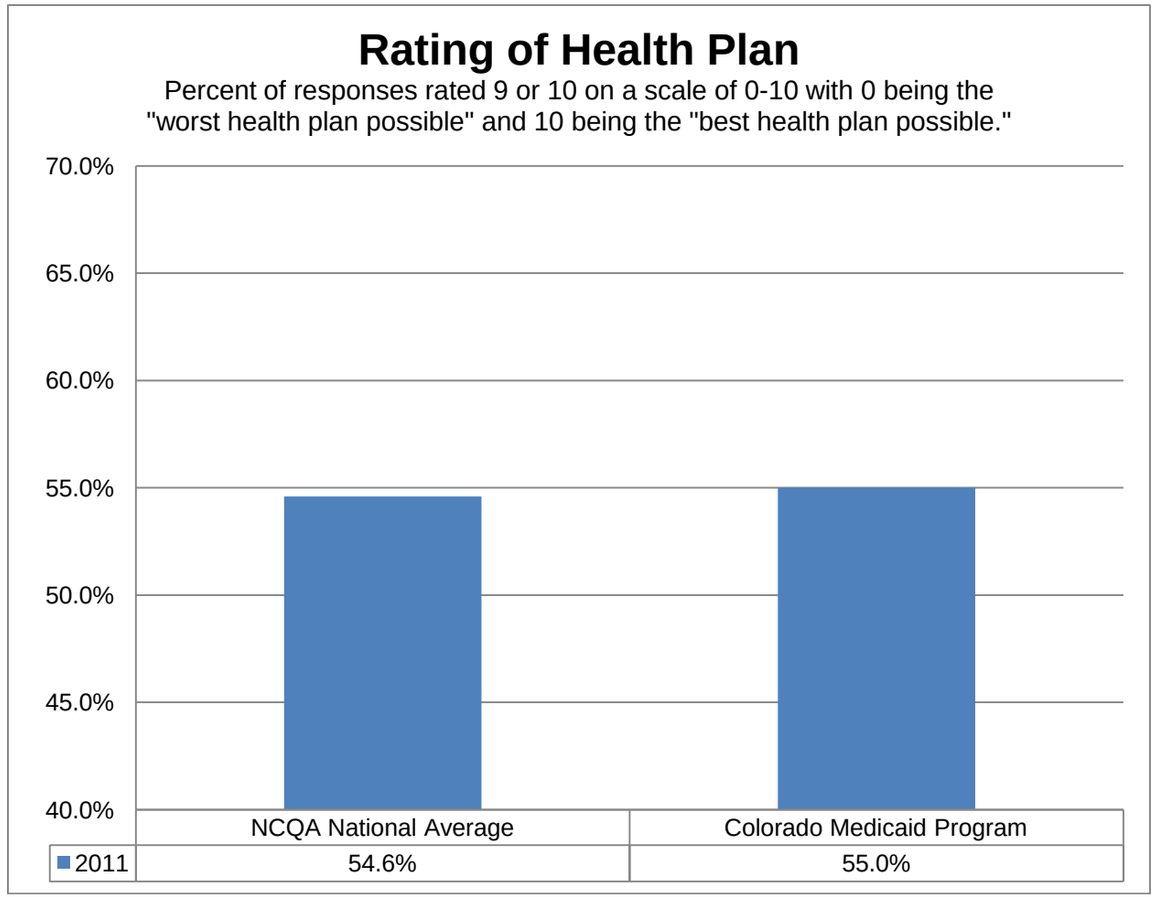
Strategy I.E. Client Experience & Engagement: *Improve the health care experience of clients while encouraging individuals to actively participate in their own health and health care through prevention and wellness.*

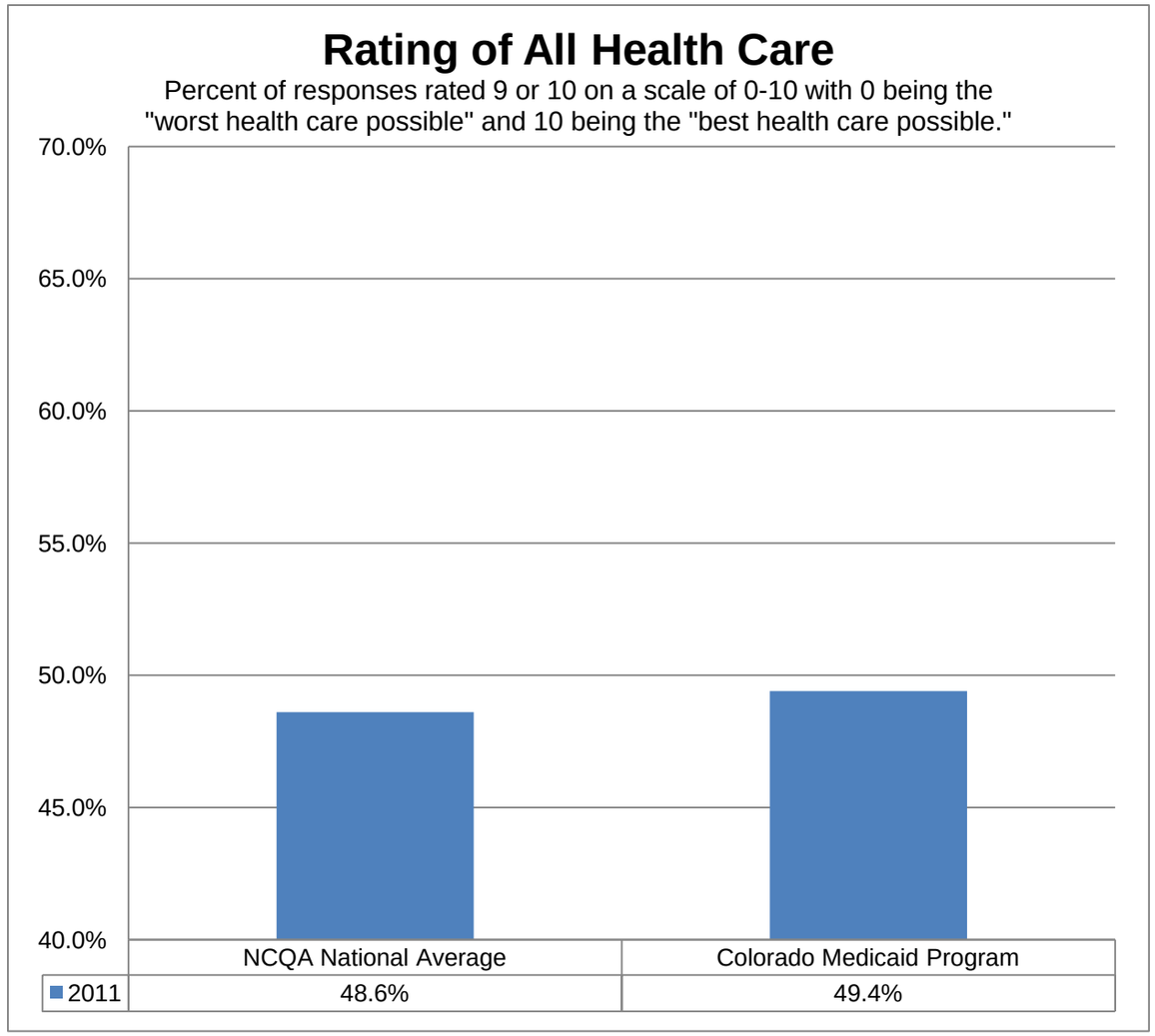
To improve the overall health care experience of clients, the Department uses a client satisfaction survey – the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Annual Client Satisfaction Report for Adults in Medicaid. The CAHPS survey allows clients who recently interacted with the Department to gauge their experience and provide input regarding satisfactory outcomes and suggested areas of improvement. The survey includes four global ratings measures: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often. Ratings for each of these measures for the Colorado Medicaid Program are derived from the combined results of the four Colorado Medicaid plans: fee-for-service, Primary Care Physician Program, Denver Health Medicaid Choice, and Rocky Mountain Health Plans. The Department uses the results of the CAHPS survey to identify opportunities to improve client service experience and implement appropriate changes through its contracts for health care services.

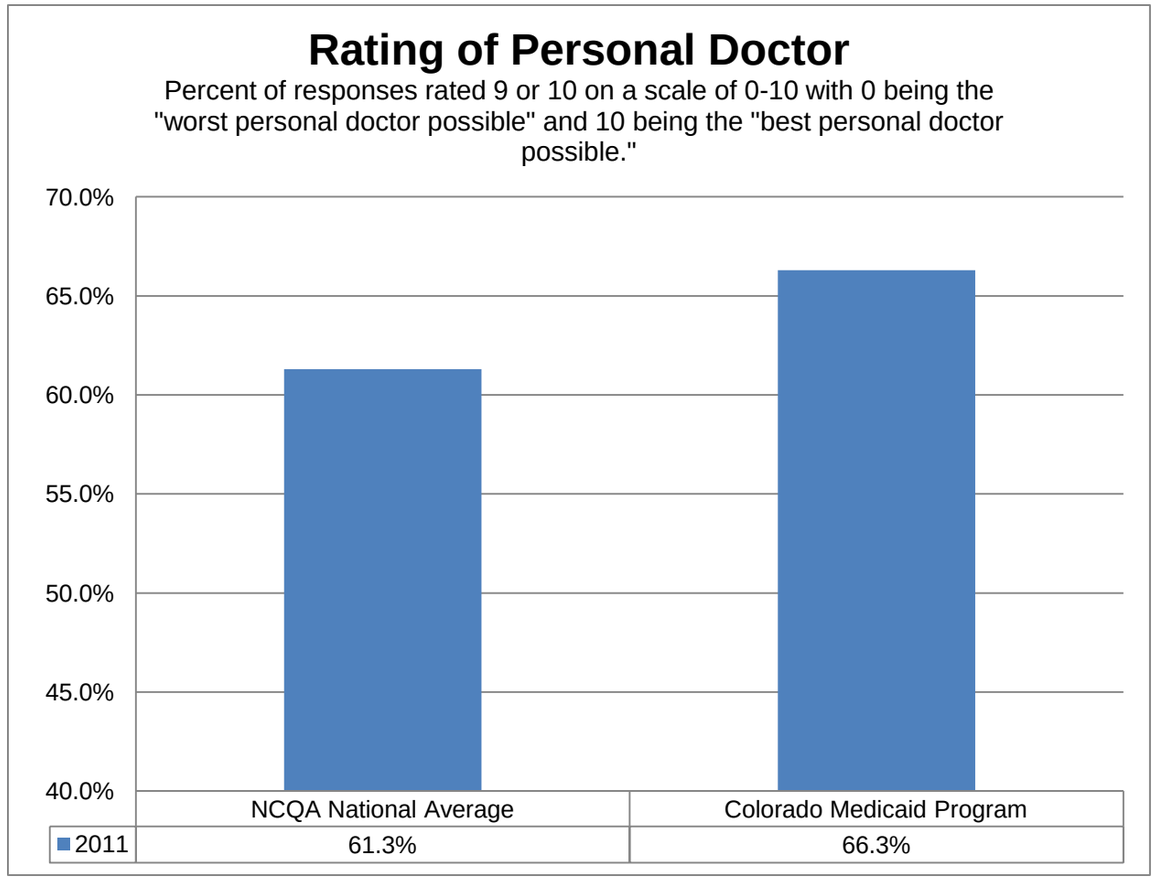
The Department's November 1, 2012 Budget Request for FY 2013-14, R-11 "HB 12-1281 Departmental Differences Reconciliation," supports this performance measure.

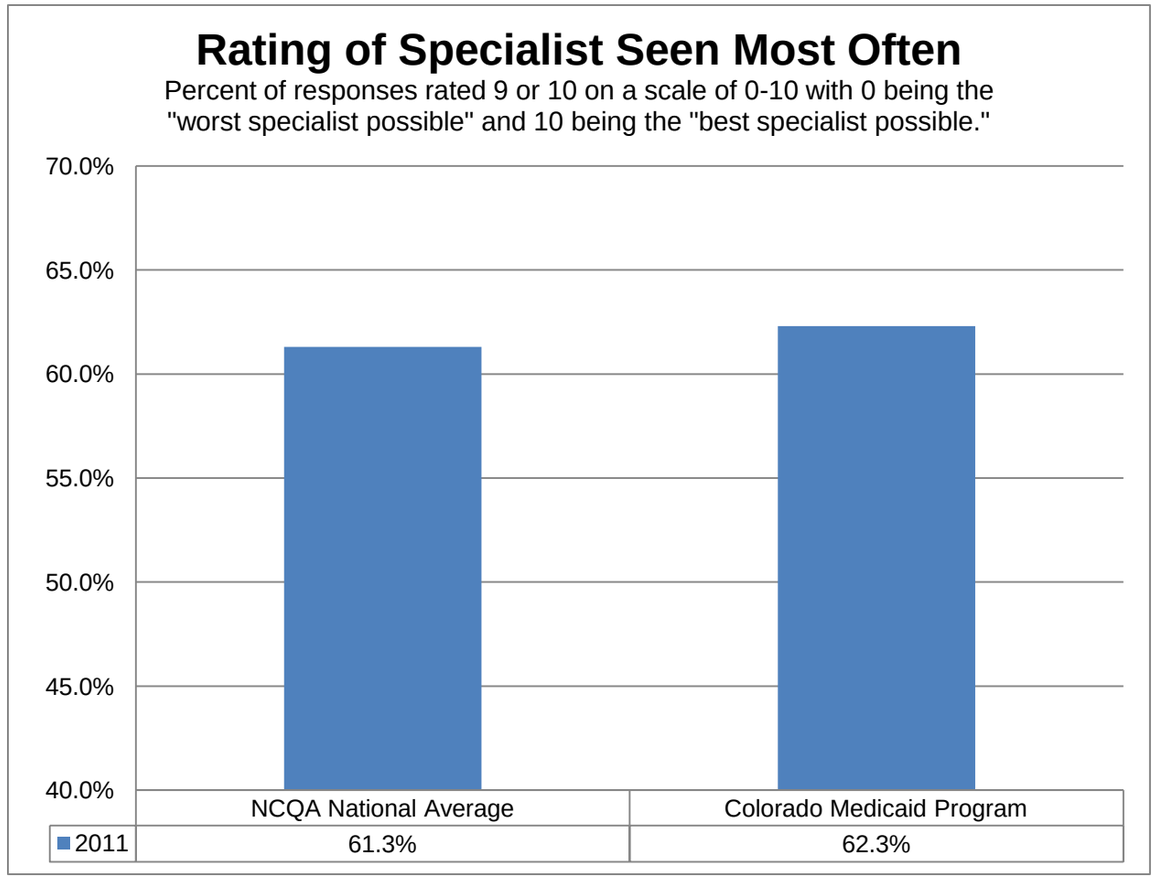
Evaluation of Prior Year Performance: National Medicaid Average scores are reported by the National Committee for Quality Assurance (NCQA) each calendar year. As of November 1, 2012, the most recent NCQA national averages available were for calendar year 2011. Due to the one-year lag in the data for national averages, the Department uses the 2011 ratings for the Colorado Medicaid Program as a proxy for data in FY 2011-12. The charts below, from the FY 2011-12 Adult Medicaid Client Satisfaction Report, show that all four global ratings measures (100%) were at or above the national average in 2011 as reported by the NCQA.

Rationale for choosing the measure: Client satisfaction surveys help the Department evaluate health care service quality. By comparing the four global ratings measures to national benchmarks, the Department can identify opportunities for improvements to operations, procedures, benefits, and other factors. In addition, these measures increase awareness of the value in improving key components of medical services.


Rating of Health Plan
Percent of responses rated 9 or 10 on a scale of 0-10 with 0 being the "worst health plan possible" and 10 being the "best health plan possible."
70.0%
65.0%
60.0%
55.0%
50.0%
45.0%
40.0%
NCQA National Average
Colorado Medicaid Program
2011
54.6%
55.0%


Rating of All Health Care
Percent of responses rated 9 or 10 on a scale of 0-10 with 0 being the "worst health care possible" and 10 being the "best health care possible."
70.0%
65.0%
60.0%
55.0%
50.0%
45.0%
40.0%
NCQA National Average
Colorado Medicaid Program
2011
48.6%
49.4%


Rating of Personal Doctor
Percent of responses rated 9 or 10 on a scale of 0-10 with 0 being the "worst personal doctor possible" and 10 being the "best personal doctor possible."
70.0%
65.0%
60.0%
55.0%
50.0%
45.0%
40.0%
NCQA National Average
Colorado Medicaid Program
2011
61.3%
66.3%


Rating of Specialist Seen Most Often
Percent of responses rated 9 or 10 on a scale of 0-10 with 0 being the "worst specialist possible" and 10 being the "best specialist possible."
70.0%
65.0%
60.0%
55.0%
50.0%
45.0%
40.0%
NCQA National Average
Colorado Medicaid Program
2011
61.3%
62.3%

Performance Measure I.E.2.b. Number of Adult Core Medicaid Quality Measures Reported to the Centers for Medicare and Medicaid Services and the Public											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	N/A	N/A	12	TBD	15	TBD	18	TBD	24	TBD

Type: Output
Frequency: ☐Monthly ☐Quarterly ☐Semi-Annually ☒Annually ☐Other

Goal: I. Improve health outcomes, client experience and lower per capita costs* (Customer) **Adapted from the Institute for Healthcare Improvement's Triple Aim.*

Strategy I.E. Client Experience & Engagement: *Improve the health care experience of clients while encouraging individuals to actively participate in their own health and health care through prevention and wellness.*

In an effort to align performance improvement efforts throughout the country, the Centers for Medicare and Medicaid Services (CMS) recently announced a list of 26 quality measures for states to voluntarily report on an annual basis. At the present time, the Department collects data on 12 of these measures, and will report annually to CMS once federal guidance becomes available on the methodology. Performance on these measures will also be posted to the Department's web site with national Medicaid averages for comparison purposes. The 12 reported measures include:

- Adult Weight Screening and Follow-Up
- Tobacco Use Assessment and Tobacco Cessation Intervention
- Chlamydia Screening for Women ages 21-24
- Diabetes: Hemoglobin A1c testing
- Inpatient admissions for short-term complication of diabetes
- Inpatient admissions for chronic obstructive pulmonary disease
- Timeliness of postpartum care
- Diabetes: LDL screening
- Consumer Assessment of Healthcare Providers and Systems survey
- Inpatient admissions for adult asthma
- Annual monitoring for patients on persistent medications
- Inpatient admissions for congestive heart failure

Evaluation of Prior Year Performance: Not applicable. New measure effective FY 2012-13.

Rationale for choosing the measure: Increasing the number of Medicaid quality measures reported will help align the Department's efforts with those identified by CMS and provide transparency for the quality of care provided to Colorado Medicaid clients. Expanding the methods of reporting on quality measures will increase awareness of quality, cost and client satisfaction with services so that strategies for continuous improvement can be developed.

Performance Measure I.E.3.a. Annual Average Percent of Incoming Phone Calls Answered by Customer Service Center											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	N/A	50%	65%	TBD	72%	N/A	73%	N/A	75%	TBD

Type: Outcome
Frequency: ☒Monthly ☐Quarterly ☐Semi-Annually ☐Annually ☐Other

Goal: I. Improve health outcomes, client experience and lower per capita costs* (Customer) **Adapted from the Institute for Healthcare Improvement's Triple Aim.*

Strategy I.E. Client Experience & Engagement: *Improve the health care experience of clients while encouraging individuals to actively participate in their own health and health care through prevention and wellness.*

The Department's call center staff is focused on improved productivity to increase the number of calls answered and reduce calls abandoned. It is estimated that 68% of staffed time should be used to handle calls, with the remaining 32% used for work functions that cannot be performed with the caller on line (e.g., creating and processing client fulfillment requests). In addition, processes are being evaluated using LEAN strategies with the aim of reducing staff handling and processing time. These efforts are expected to increase the number of calls answered within the same time interval while reducing the number of calls abandoned.

The Department's November 1, 2012 Budget Request for FY 2013-14, R-6 "Additional FTE to Restore Functionality" and R-12 "Customer Service Technology Improvements" support this performance measure.

Evaluation of Prior Year Performance: Not applicable. New measure effective FY 2012-13.

Rationale for choosing the measure: Answered and abandoned calls are not the only measure of success. Others include first call resolution, accuracy and quality evaluation, and customer satisfaction. All of these, if positive, contribute to an environment where handle time is lowered and repeat calling is reduced. This results in a reduction in calls presented, which directly affects the number of calls potentially abandoned. By measuring the percent of calls answered as an indicator of overall customer service quality, the Department can take steps to increase calls answered and thereby improve client experience.

Performance Measure I.E.3.b. Annual Average Percent of Incoming Phone Calls Abandoned by Customer											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	N/A	50%	35%	TBD	28%	N/A	27%	N/A	25%	TBD

Type: Outcome
Frequency: ☒Monthly ☐Quarterly ☐Semi-Annually ☐Annually ☐Other

Goal: I. Improve health outcomes, client experience and lower per capita costs* (Customer) **Adapted from the Institute for Healthcare Improvement's Triple Aim.*

Strategy I.E. Client Experience & Engagement: *Improve the health care experience of clients while encouraging individuals to actively participate in their own health and health care through prevention and wellness.*

The Department's call center staff is focused on improved productivity to increase the number of calls answered and reduce calls abandoned. It is estimated that 68% of staffed time should be used to handle calls, with the remaining 32% used for work functions that cannot be performed with the caller on line (e.g., creating and processing client fulfillment requests). In addition, processes are being evaluated using LEAN strategies with the aim of reducing staff handling and processing time. These efforts are expected to increase the number of calls answered within the same time interval while reducing the number of calls abandoned.

The Department's November 1, 2012 Budget Request for FY 2013-14, R-6 "Additional FTE to Restore Functionality" and R-12 "Customer Service Technology Improvements" support this performance measure.

Evaluation of Prior Year Performance: Not applicable. New measure effective FY 2012-13.

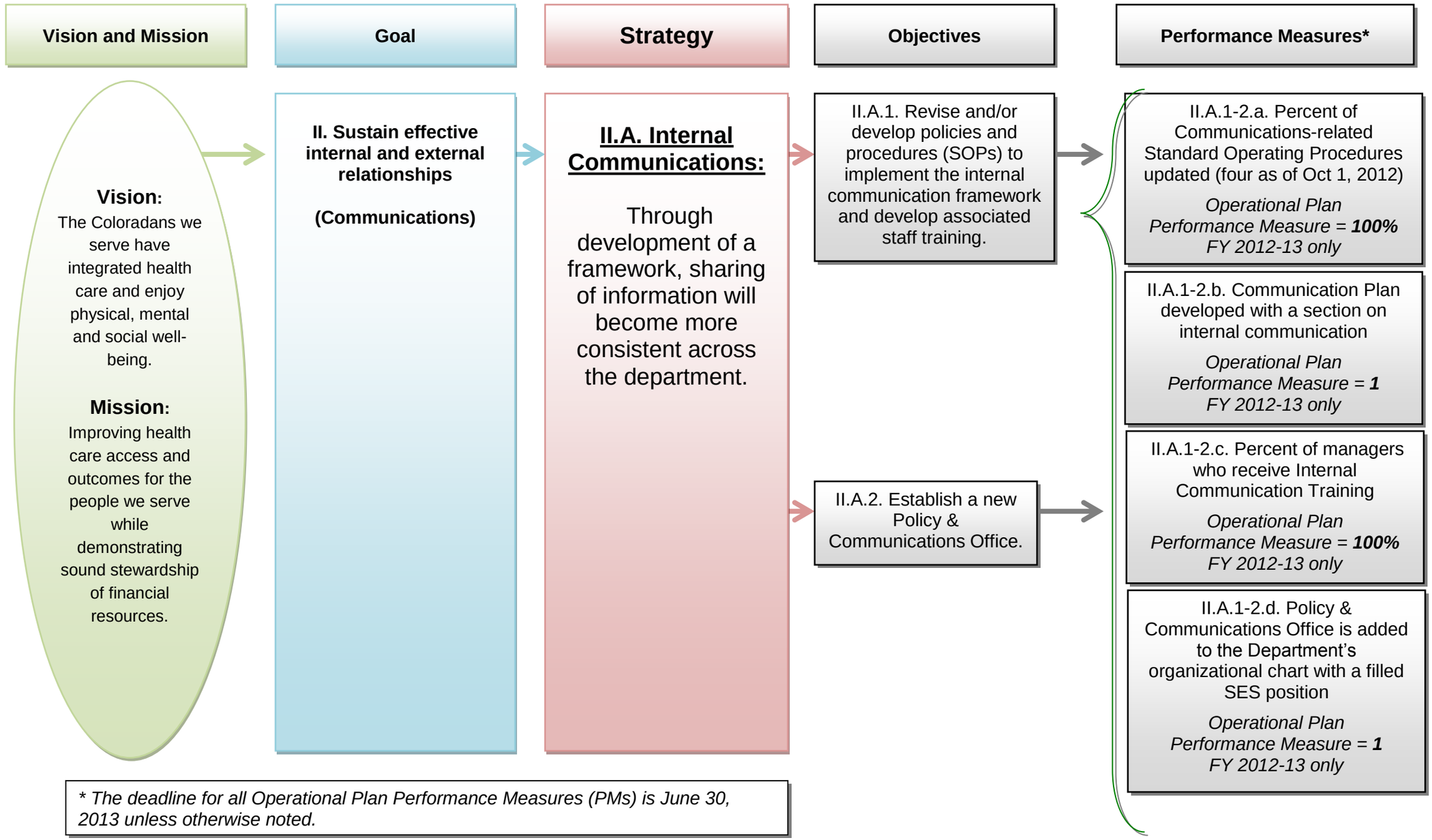
Rationale for choosing the measure: Answered and abandoned calls are not the only measure of success. Others include first call resolution, accuracy and quality evaluation, and customer satisfaction. All of these, if positive, contribute to an environment where handle time is lowered and repeat calling is reduced. This results in a reduction in calls presented, which directly affects the number of calls potentially abandoned. By measuring the percent of calls abandoned as an indicator of overall customer service quality, the Department can take steps to decrease the abandonment rate and thereby improve client experience.

Goal II

II. Sustain effective internal and external relationships.

(Communications)

Strategy Map Logic Model - Goal II, Strategy A



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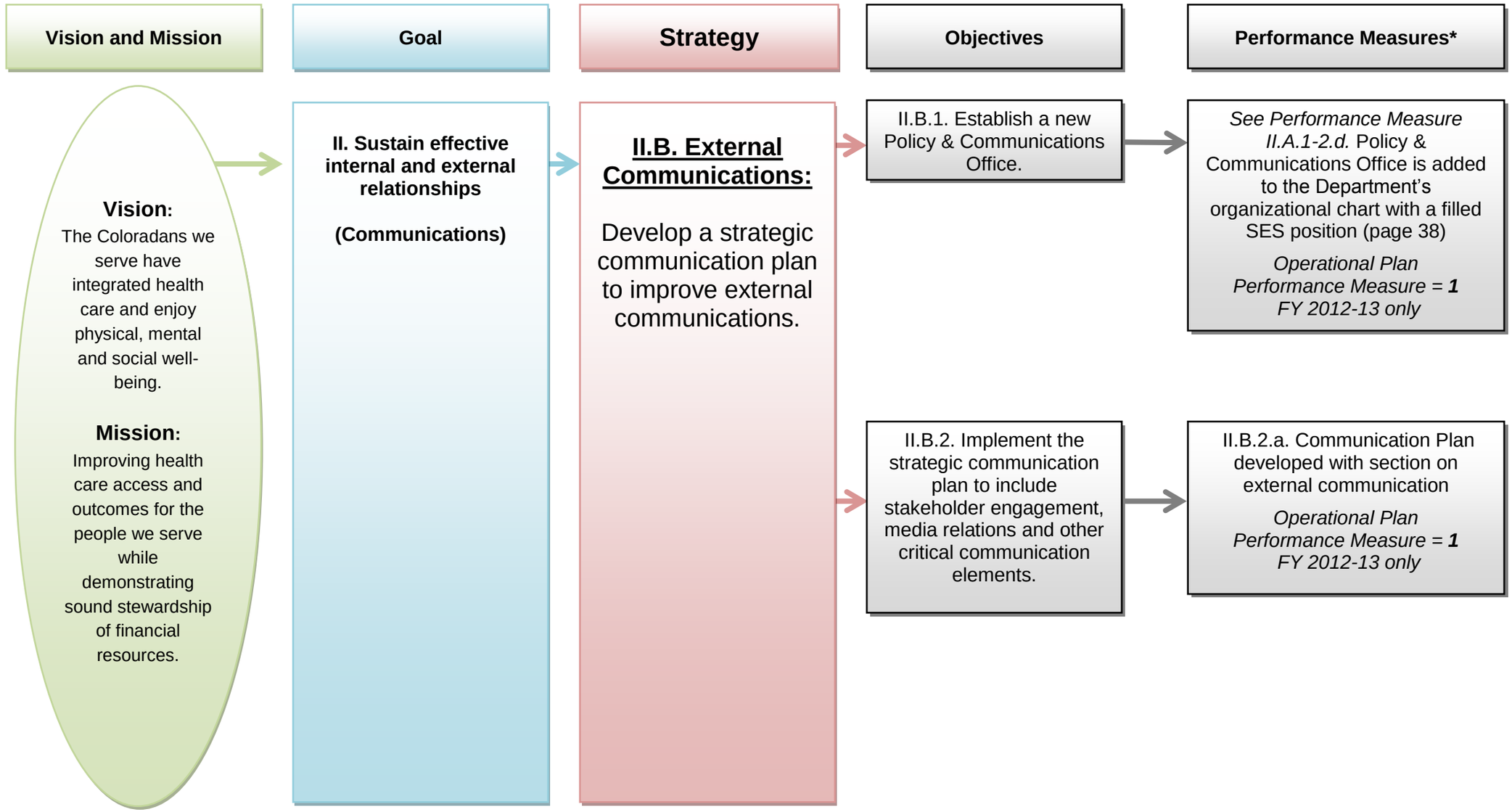
Strategy Map Logic Model - Goal II, Strategy B



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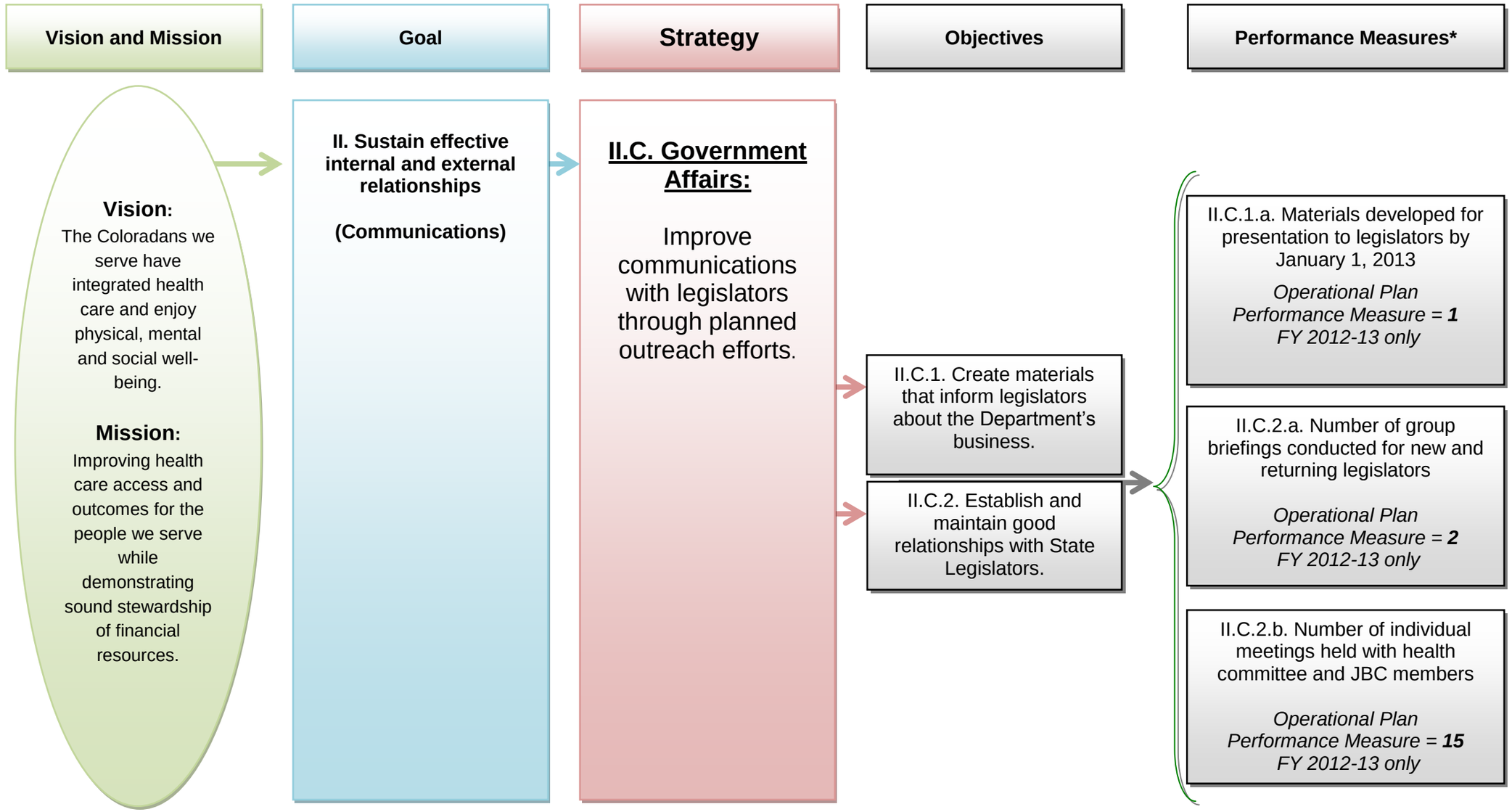
Strategy Map Logic Model - Goal II, Strategy C



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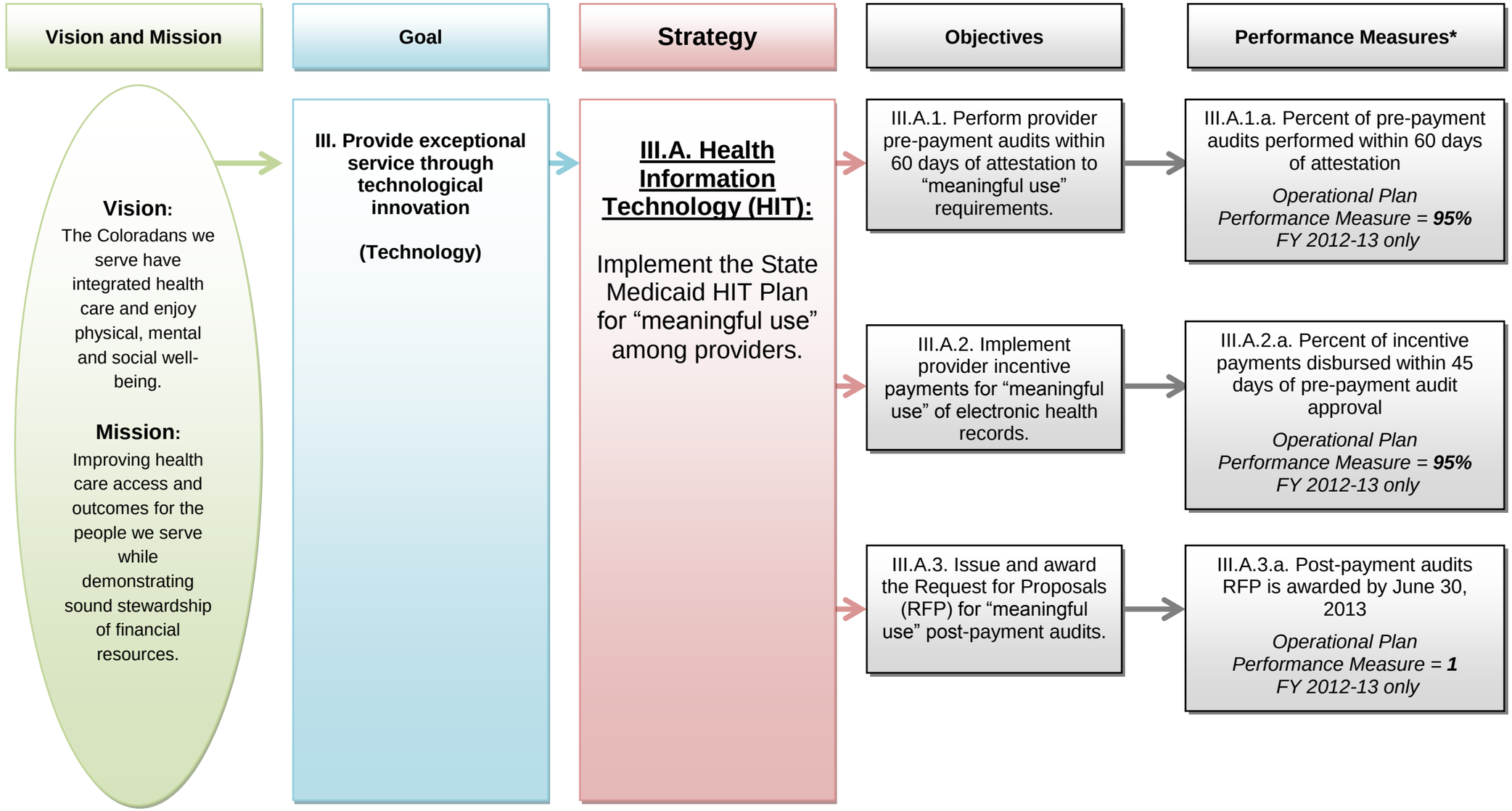
Goal III

III. Provide exceptional service through technological innovation.

(Technology)

Strategy Map Logic Model - Goal III, Strategy A



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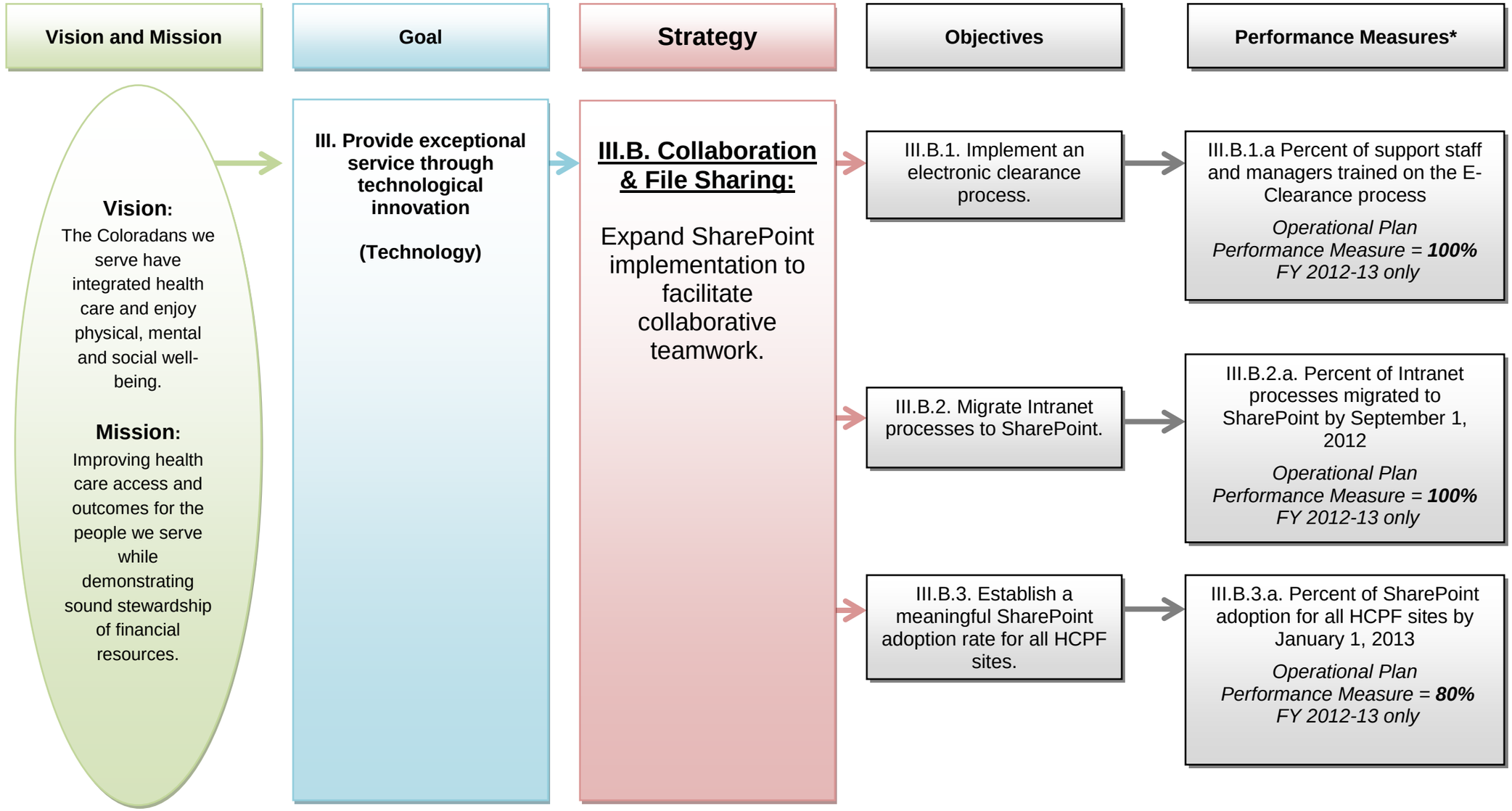
Strategy Map Logic Model - Goal III, Strategy B



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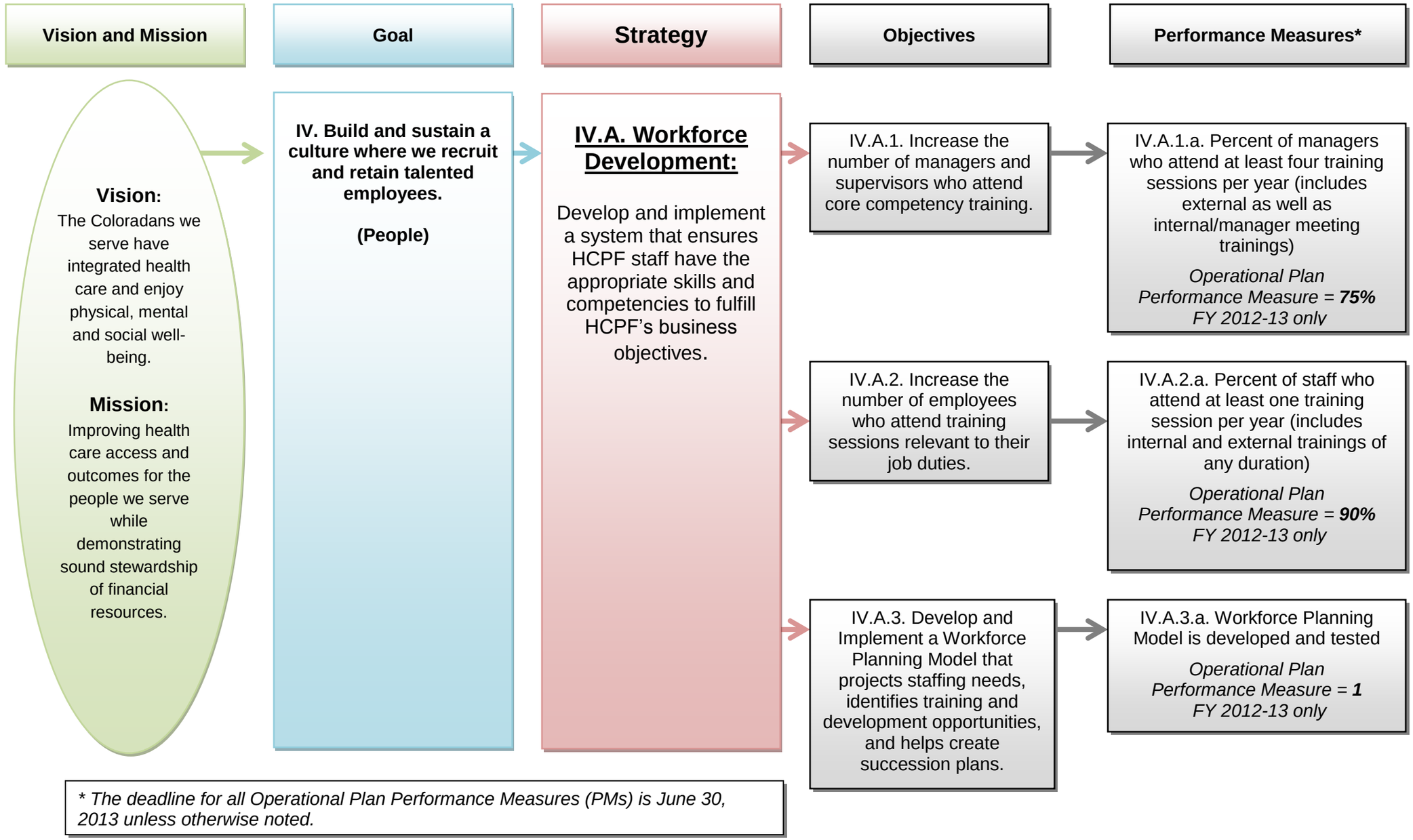
Goal IV

IV. Build and sustain a culture where we recruit and retain talented employees.

(People)

Strategy Map Logic Model - Goal IV, Strategy A



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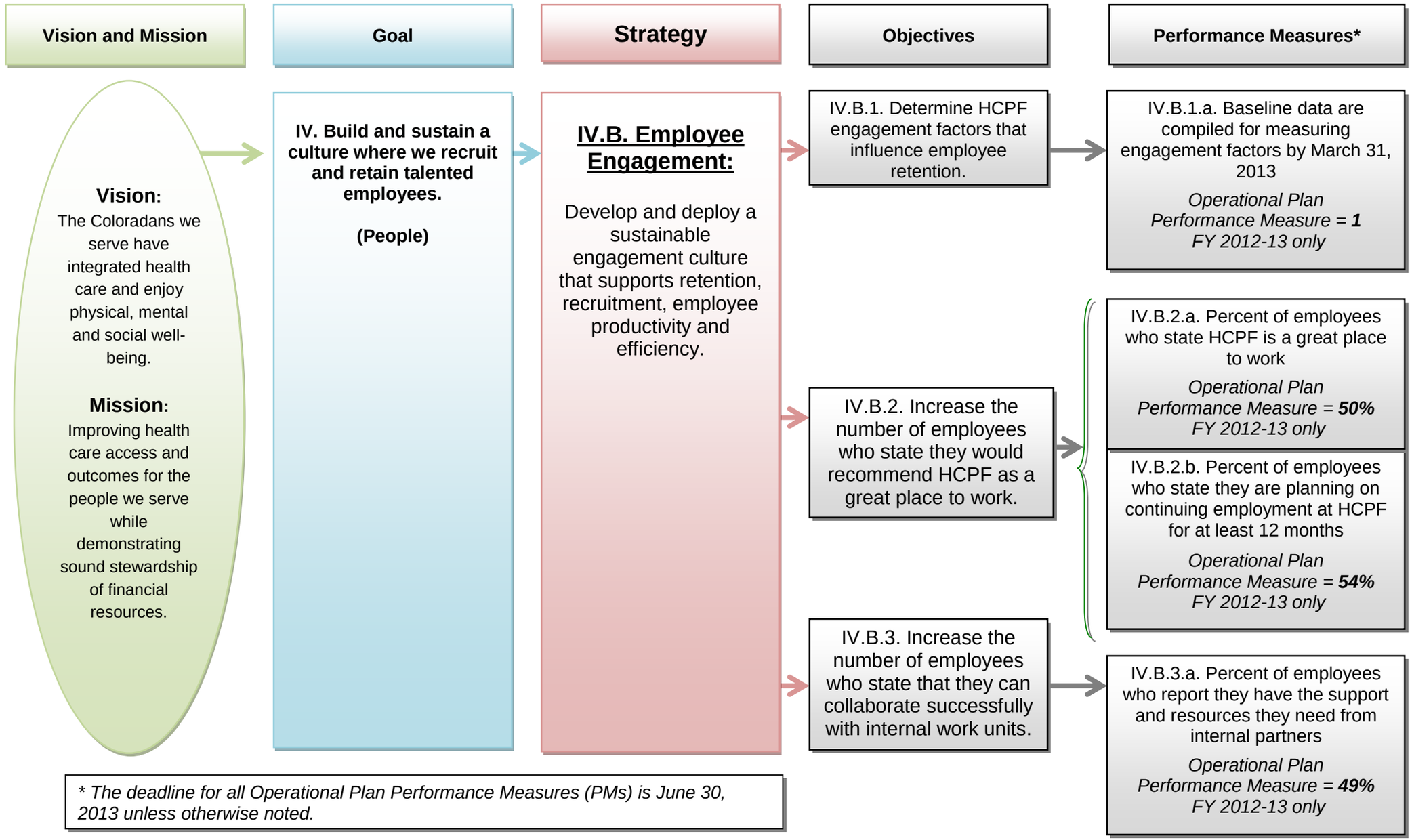
Strategy Map Logic Model - Goal IV, Strategy B



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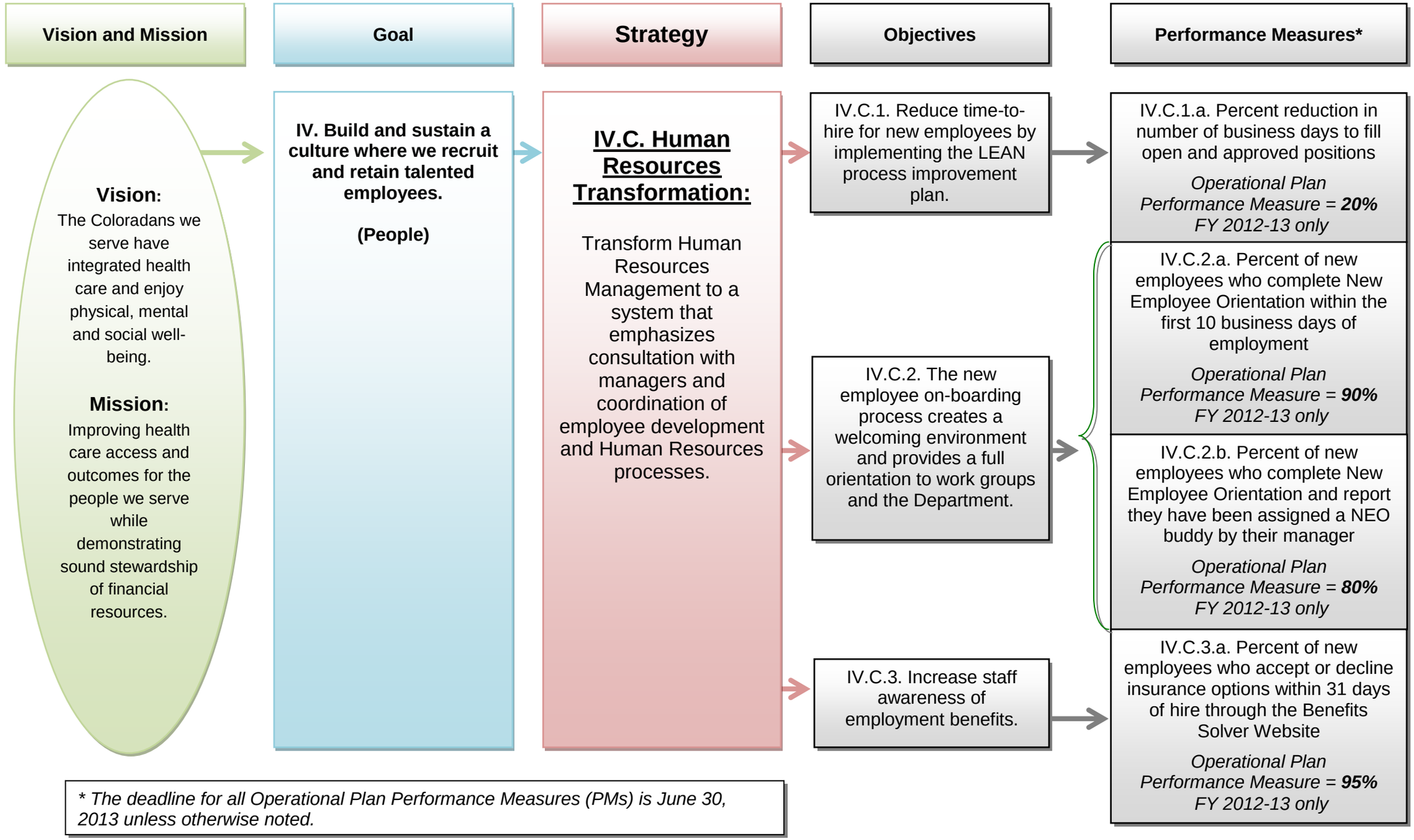
Strategy Map Logic Model - Goal IV, Strategy C



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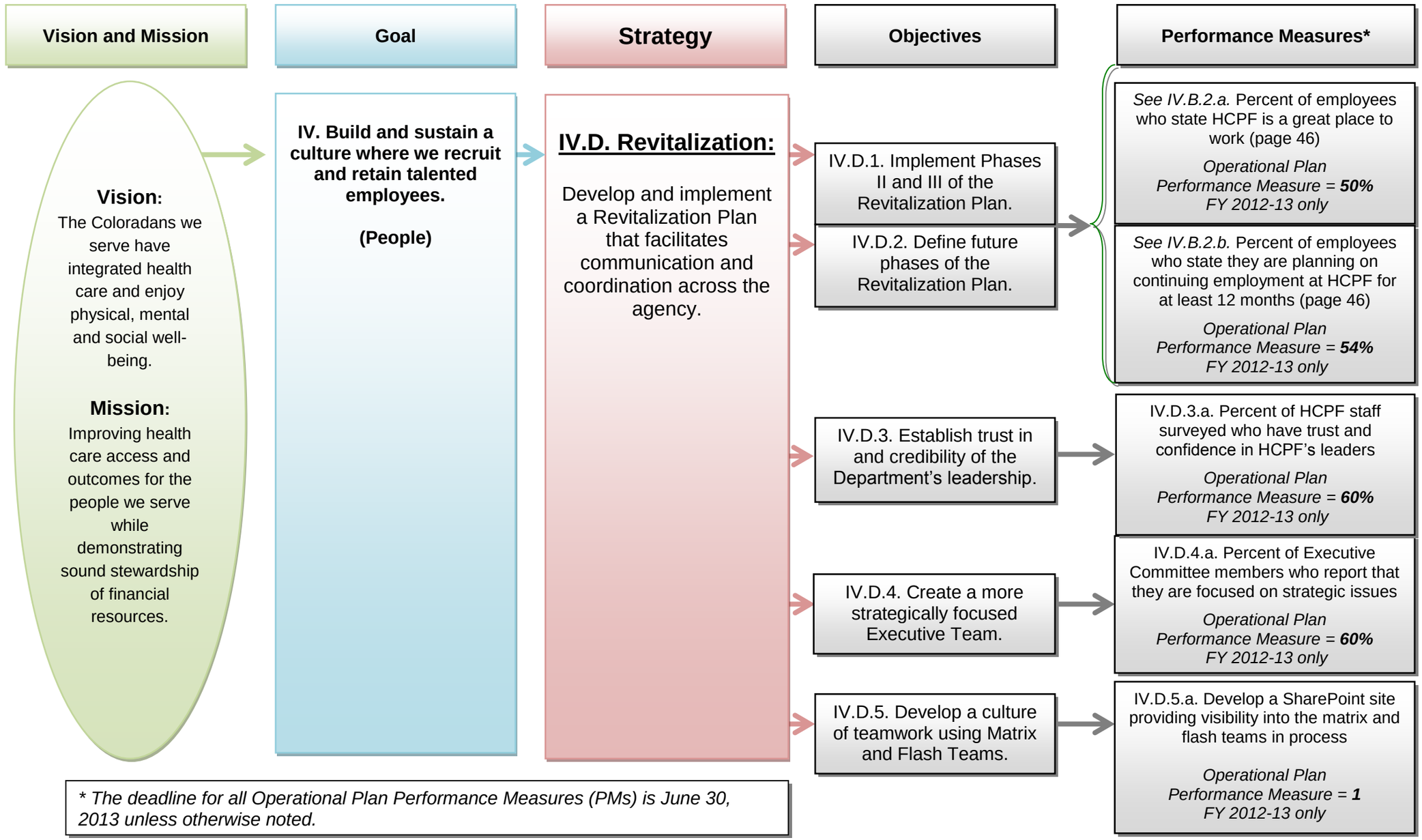
Strategy Map Logic Model - Goal IV, Strategy D



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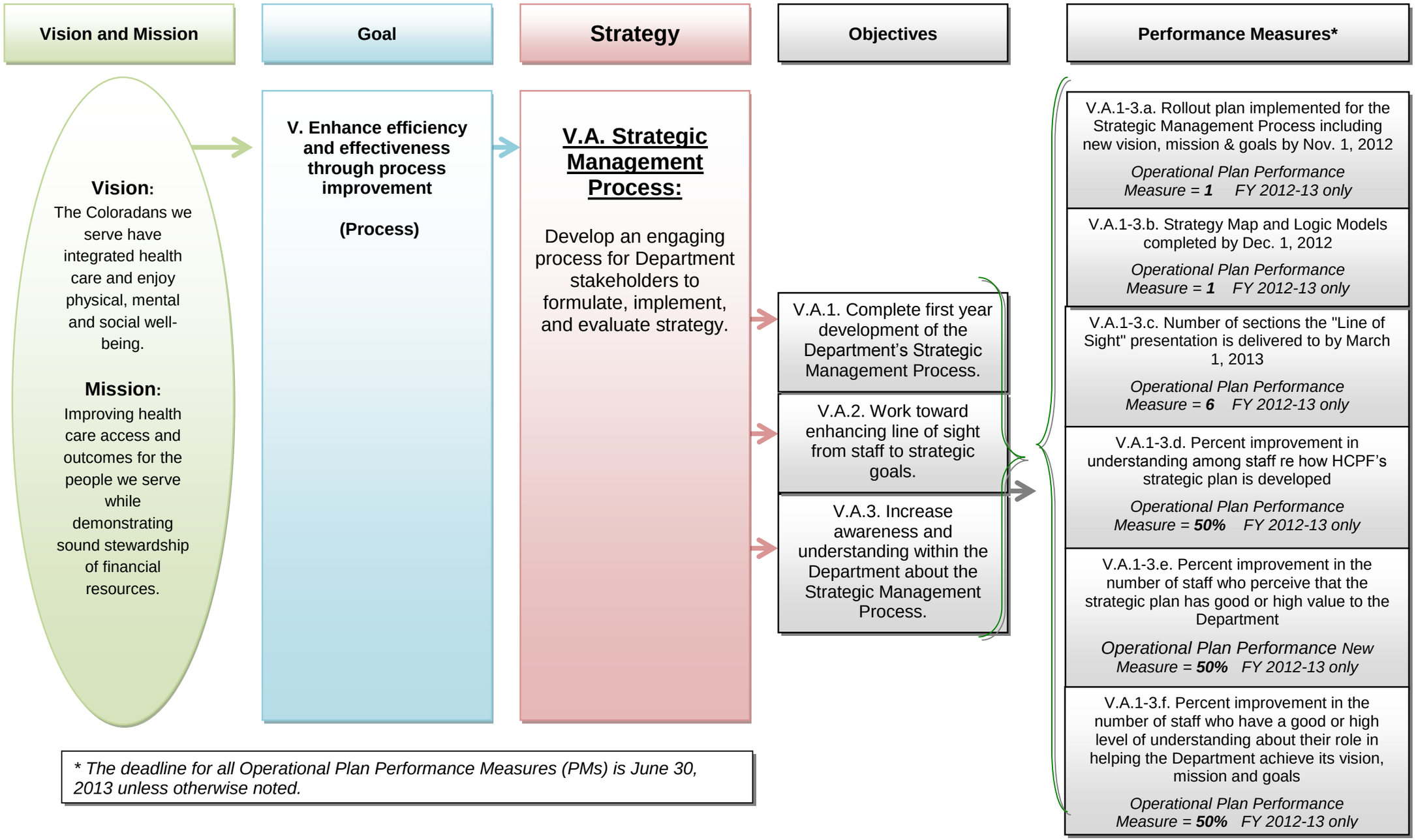
Goal V

V. Enhance efficiency and effectiveness through process improvement.

(Process)

Strategy Map Logic Model - Goal V, Strategy A



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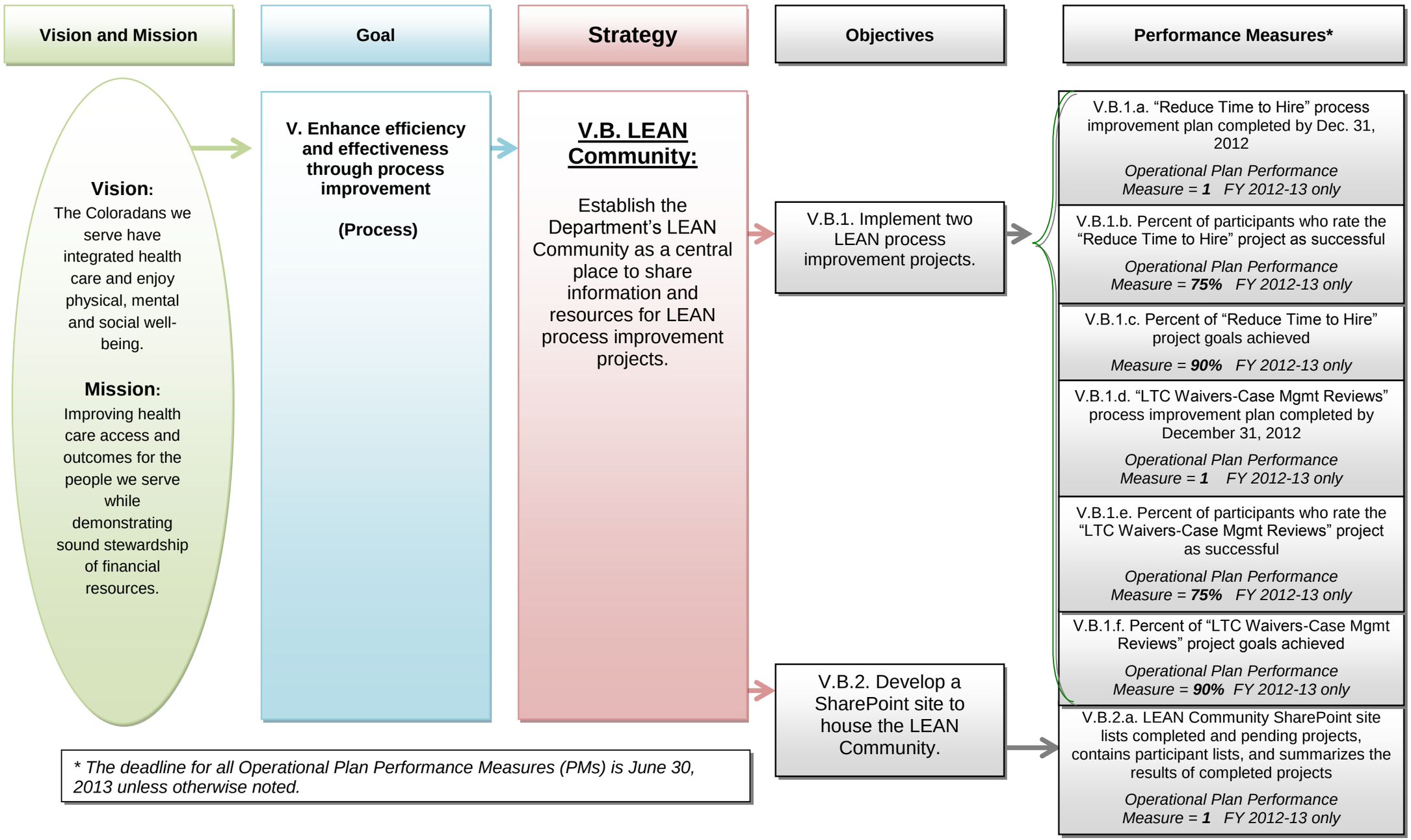
Strategy Map Logic Model - Goal V, Strategy B



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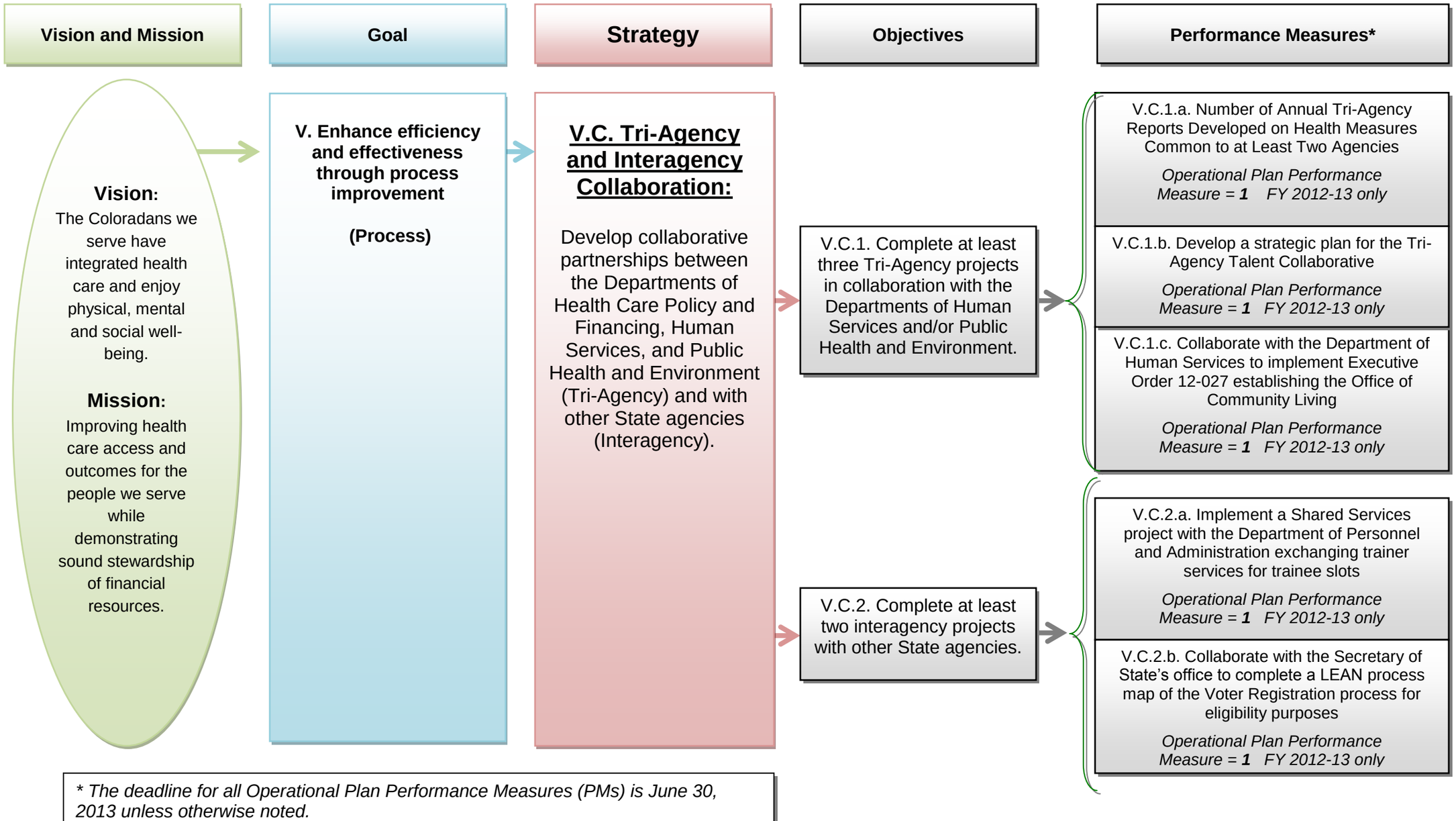
Strategy Map Logic Model - Goal V, Strategy C



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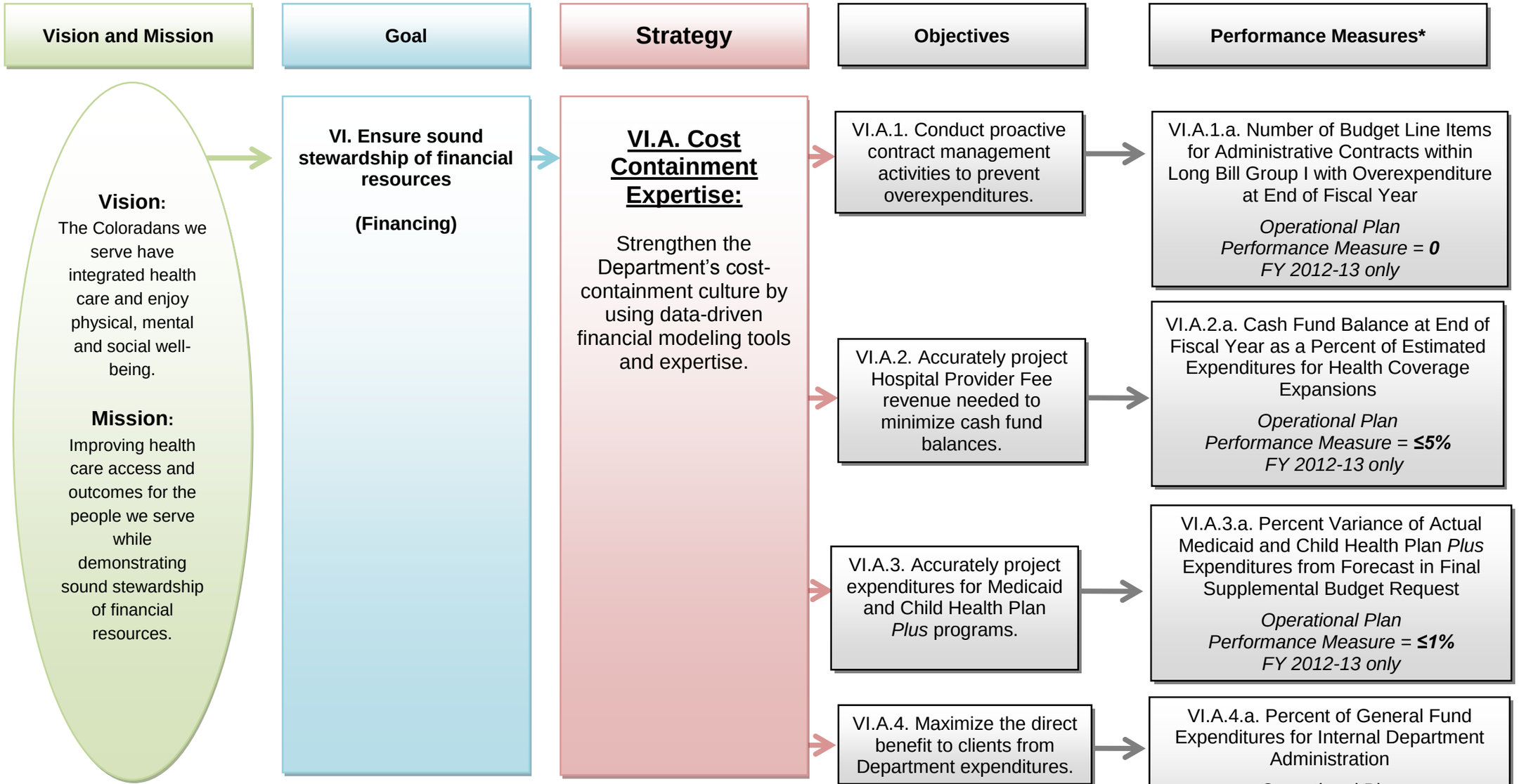
Goal VI

VI. Ensure sound stewardship of financial resources.

(Financing)

Strategy Map Logic Model - Goal VI, Strategy A



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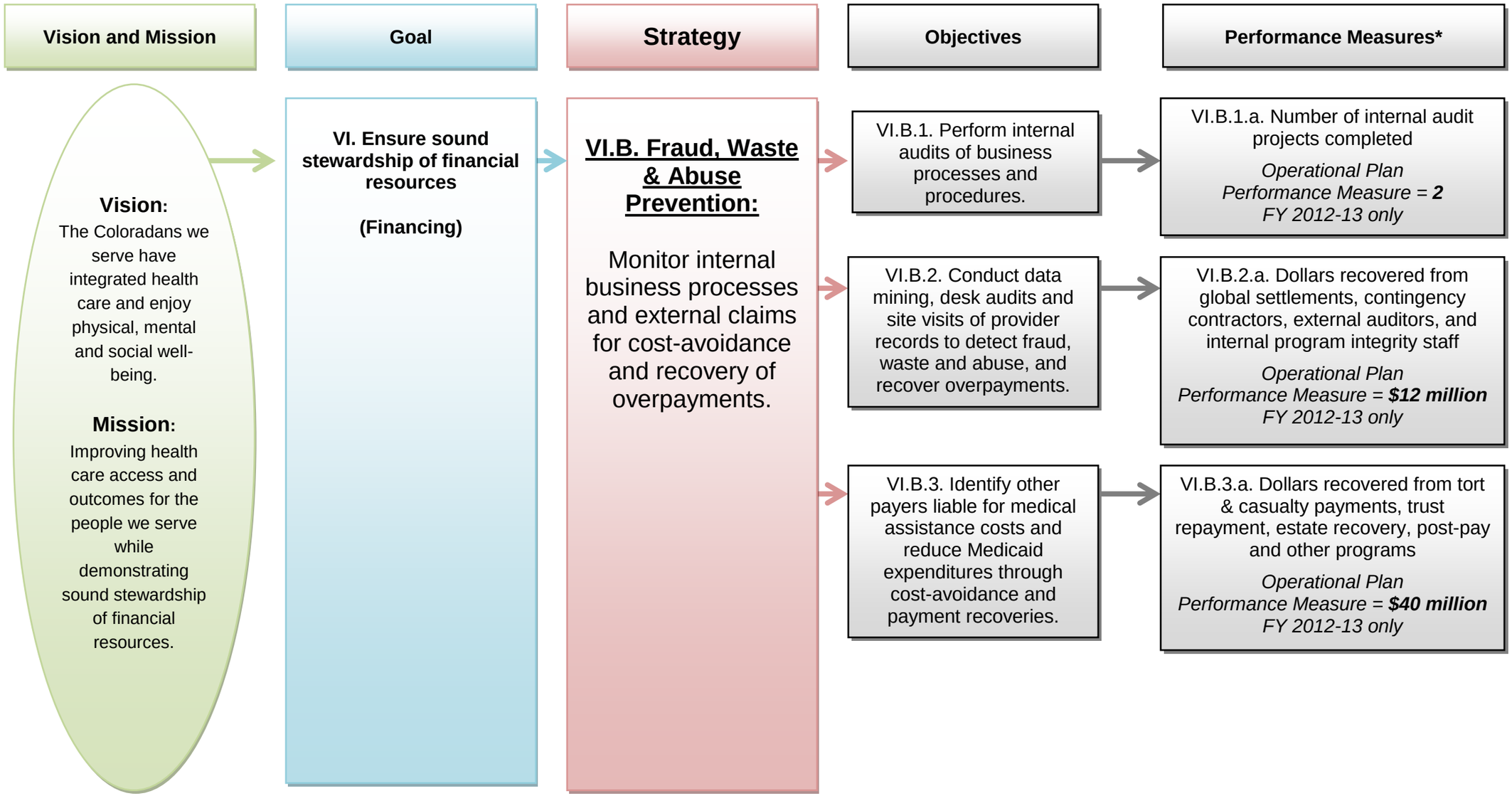
Strategy Map Logic Model - Goal VI, Strategy B



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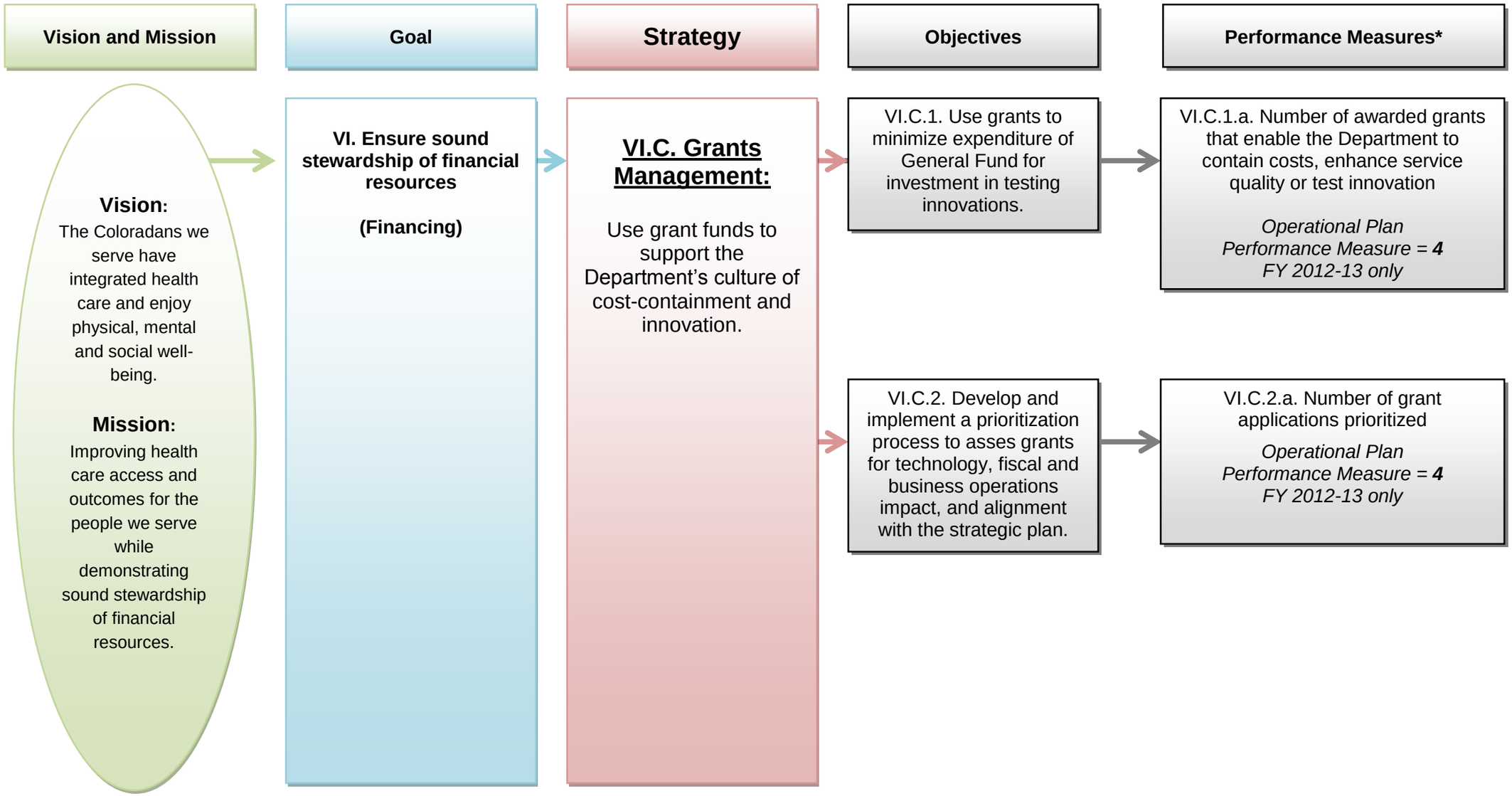
Strategy Map Logic Model - Goal VI, Strategy C



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